7.2 Authorize RI Medicaid Service

7.2.1 MITA Business Process

Tier 3: Authorize Service	
Item	**Details**
Description	The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting. The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process. Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary. After review, a referral is approved, modified, denied or pended for additional information. The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication. A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made. A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes. NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, Inpatient, Out-of-State Services, and Emergencies.

7.2.2 RI Business Process Overview

Many procedure codes require prior authorization before reimbursement will be made by Medicaid. The Department of Human Services' Operations and Payments oversees the Authorize RI Medicaid Service business process for all hospital, physician, dental, and pharmacy authorizations. The MMIS Fiscal Agent, HP, performs the steps

associated with the business process with intervention from the DHS required for specialty drugs or non-standard PA's.

Prior Authorization for all outpatient MRI, CT and PET imaging studies are administered by MedSolutions. Referring providers are required to obtain prior authorizations directly from MedSolutions.

For Medicaid services managed by the Department of Children, Youth and Families (DCYF), HP creates the PA within the MMIS for claims adjudication.

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals oversee the Authorize Standard RI Medicaid Services business process for mental health and substance abuse services.

7.2.3 Business Process Variations

The Authorize RI Medicaid Service business process does not significantly diverge from the MITA business process definition.

7.2.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

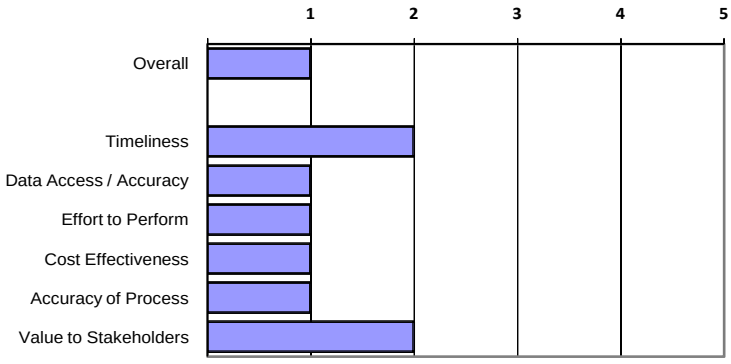
- RI-MMIS–used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- Pharmacy POS– Point of Sale system used to process pharmacy claims and authorization with real-time transactions.
- Interactive Web Services – used by providers for recipient eligibility verification; check the status of a submitted claim; check the status of a prior authorization request; pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program; confirm their Medical

Assistance payment history for the last 12 months; and view their Remittance Advice (RA) electronically in the paper RA format.

7.2.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Authorize Service process are rated at a Level 1 with the exception of Timeliness and Utility or Value to Stakeholders.

Figure 25 Current Maturity Levels by Dimension: Authorize Standard RI Medicaid Service



Examples supporting these Authorization RI Medicaid Service process ratings include the following:

- Authorization are primarily submitted on paper
- Paper or faxed authorization submissions receive responses or requests for additional information via fax or mail
- Most authorizations are manually reviewed for medical necessity
- Only Pharmacy authorizations are HIPAA compliant.

Table 24 Assessed Maturity Level by MITA Quality: Authorize RI Medicaid Service

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1	2
Data Access & Accuracy	**1**
Authorize Service request is a mix of paper/phone/fax and EDI.	2
Format and content are not HIPAA compliant.	1
Inflexibility in Authorize Service processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver programs that determine medical appropriateness and service authorization differently than traditional Medicaid programs. As a result, data is not comparable across silos.	1
Requests may be accepted by internet Web portals, email, dial-up, and via transferable electronic media such as disks and tape. This increases the number of small providers who can submit Authorize Service requests electronically.	2
Preconditions for achieving this level are use of established RHIOs and semantic interoperability. (Level 4 Only)	N/A
Effort to Perform	**1**
Information is manually validated and manually transferred from submitted paper to the MMIS.	1
If an Authorize Service request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive.	1
Related processes are de-coupled, allowing changes to be made in the Authorize Service process with reduced potential for unintended downstream processing consequences. (Level 3 Only)	N/A
Cost Effectiveness	**1**
Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP)..	1
Accuracy of Process	**1**
Authorize Service requests are primarily manually validated against state-specific business rules. As a result, states may conduct Authorize Service retrospectively as an audit, missing opportunities to ensure appropriate use of services.	1

MITA BCM Qualities & Characteristics	Level
Related processes are tightly integrated, making it difficult to ensure that changes to service authorization process do not result in unintended cross-process consequences.	1
Utility or Value to Stakeholders	**2**
The agency benefit from introduction of automation.	2

7.3 Establish Care Plan

7.3.1 MITA Business Process

Tier 3: Authorize Treatment Plan	
Item	**Details**
Description	The Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan. A Treatment Plan prior-authorizes the named providers and services. The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time. A service request is more limited and focuses on a specific visits, services, or products. The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary. After reviewing; approves, modifies, pends or denies the request and sends the appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the Manage Provider Communication process or sending a 277 Request for Additional Information to the provider. A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.

7.3.2 RI Business Process Overview

The Establish Care Plan process for DHS waivers and other community programs is overseen by the Office of Institutional and Community Services and Supports (OICSS). Within OICSS, Core and Preventative Services, the office of Community Programs (OCP), and the Office of Medical Review (OMR) perform most of the Establish Care Plan process. The OICSS staff then work with support brokers and Fiscal Agents to manage the care plan for the beneficiary.

The OMR performs a level of care assessment which determines a beneficiaries need to be Core (Highest or High) or Preventive. Core services are defined as Long-Term

Care for those applicants that have been determined clinically to be in need of a high or highest level of care category. Preventive services are for individuals who are categorically eligible for Medicaid, yet do not meet the highest or high levels of clinical need for long-term care services, but who need a basic level of community-based services so that they may safely remain in their homes.

The results of the level of care assessment determines which waiver program best meets the beneficiary's needs. The following waiver programs include the establishment of a care plan:

- Personal Choice – Upon receipt of client's mobility, nursing, and social work evaluations from one of two contracted agencies: 1) TriTown Community Agency or 2) PARI, the OMR will determine a Level of Care (LOC). Once a LOC is assigned, a "self-care" budget for services will be determined. The evaluation and budget information are maintained in CDM. CDM is viewable by case workers, agencies, and the client.
- Habilitation – Typically these are traumatic brain injury or severely disabled clients. The OMR will receive a proposed treatment plan from the referring hospital which initiates the determination of LOC. LOC information is stored in the OMAR system. One of two contracted agencies: 1) TriTown Community Agency or 2) PARI, completes the client's mobility, nursing, and social work evaluations and proposes a care plan and budget for the client. Upon approval from DHS, the care plan is returned to the hospital and ongoing case management is performed by the agency. Expenditures are tracked in a Excel Workbook.
- Nursing Home Transition – Client assessments are conducted by the OCP. Assessment information is housed in an Access Database. OCP determines transition plan to either the Department of Elderly Affairs (DEA), Mental Retardation/Developmental Disabilities (MR/DD), standard Medicaid Long Term Care (LTC) or where ever the client was prior to residing in the Nursing Home. A care plan is established based on the assessment. A "case" is opened for the transition period.

- High Cost Cases and Complex Duals – These are usually LTC clients that already have a level of care established. OCP Registered Nurses manage these cases and collaborate on the care plan with LTC Workers. Cases are tracked in an Excel spreadsheet.
- Preventative – These are services paid under straight Medicaid for clients that applied for Home and Community Based Services (HCBS) or LTC and do not qualify. Typically these are clients that need minimal in-home personal care or homemaker services. OCP Social Workers perform a case management assessment. OMR performs a level of care assessment. The Global Waiver Service Plan (GWSP) paper form is used to establish the care plan. OCP stores cases in paper file folders. OMR stores level of care information in the OMAR system.
- Assisted Living and Community Waivers - The Department of Elderly Affairs (DEA) also administers an assisted living waiver for those ages 65 and older. Cases are referred to DEA and the cases are entered into the Social Assistance Management System (SAMS). DEA works with four (4) Case Management Agencies to perform an assessment on the client. The Case Management Agency will collect three pieces of information: 1) the Universal Client Assessment Tool (UCAT), 2) the DHS approved LTC application and 3) Level of care determination by OMR. All three pieces of information are entered into SAMS. DEA approves treatment plan in SAMS.

The Division of Developmental Disabilities at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) conducts clinical eligibility determinations for individuals with developmental disabilities. Applicable care plans for individuals in programs administered by BHDDH are contracted to care management agencies.

7.3.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- End: Load review results into Maintain Benefits/Reference repository for access during adjudication audit process (the MMIS will pay all claims based on an assigned program indicator. Care plan authorization information is not passed to the MMIS).

7.3.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the Establish Care Plan process include:

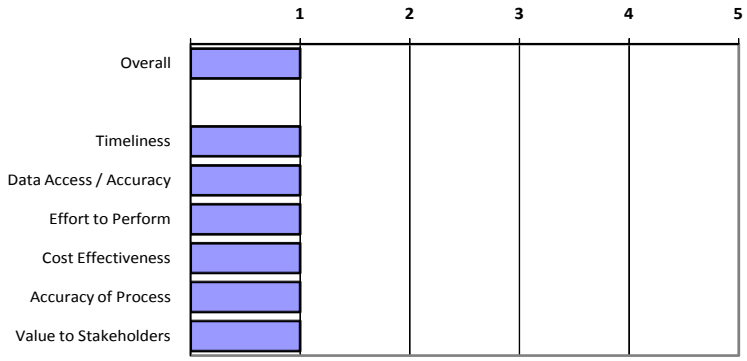
- Community Supports Management (CSM) - used for managing long-term care applications processing and care management functions
- OMAR – a web-based application developed and installed on secure laptops which are used by the Office of Medical Review's registered nurses who conduct the clinical level of care determinations in off-site locations, such as hospitals.
- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes – RI Eligibility system used for determination and enrollment information.
- Habilitation Excel Workbook – used to track individual expenditures for the Habilitation Waiver.
- Nursing Home Transition Access Database – used to track Nursing Home Transition waiver case management activities.

- High Cost Cases and Complex Duals Excel Workbook – used to track High Cost Cases and Complex Duals waiver case management activities.
- SAMS - Social Assistance Management System utilized by adult day services providers and providers of case management services. SAMS supplies client and service delivery data vital to tracking service delivery and to monitoring and evaluating home and community care programs

7.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Establish Care Plan process are rated at a Level 1.

Figure 26 Current Maturity Levels by Dimension: Establish Care Plan



Examples supporting these Establish Care Plan process ratings include the following:

- Requests are primarily paper-based
- Most activities are manual
- There is not centralized case management software. Data continues to be housed in silos.

Table 25 Assessed Maturity Level by MITA Quality: Establish Care Plan

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Timelapse of process (to enroll, assign, pay, respond, make a change or report) is within agency, state and federal guidelines.	1
Data Access & Accuracy	**1**
Authorize Treatment Plan request is primarily paper, phone or fax based.	1

MITA BCM Qualities & Characteristics	Level
Format and content are not HIPAA compliant (There is no HIPAA transaction standard for care plans at this time).	N/A
Inflexibility in Authorize Treatment Plan processing is a key factor in the proliferation of siloed systems outside of the MMIS, especially for waiver programs that determine medical appropriateness and treatment plan authorization differently than traditional Medicaid programs. As a result, data is not comparable across silos.	1
Preconditions for achieving this level are use of established RHIOs and semantic interoperability. (Level 4 only)	N/A
Effort to Perform	**1**
Information is manually validated and manually transferred from submitted paper to the MMIS.	N/A
If an Authorize Treatment Plan request requires additional information, the reviewer must manually contact the submitter/provider, which delays processing and is resource intensive.	1
Related processes are de-coupled, allowing changes to be made in the Authorize Treatment Plan process with reduced potential for unintended downstream processing consequences. (Level 3 only)	N/A
Cost Effectiveness	**1**
Since these systems duplicate MMIS capabilities and do not meet current MMIS requirements, states lose development, design, and implementation as well as operational federal funding participation (FFP).	1
Accuracy of Process	**1**
Only unstructured paper forms are used in a manual review process, so inconsistent interpretation and application of Authorize Treatment Plan rules persist. The increasing centralization of business processes promotes harmonized rules across some silos.	2
Related processes are tightly integrated, making it difficult to ensure that changes to Treatment Plan authorization process do not result in unintended cross-process consequences.	1
Utility or Value to Stakeholders	**1**
Business process complies with agency and state requirements	1

8 OPERATIONS MANAGEMENT: THIRD PARTY LIABILITY

8.1 Manage RI Medicaid Drug Rebate

8.1.1 MITA Business Process

Tier 3: Manage Drug Rebate	
Item	**Details**
Description	The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions.

8.1.2 RI Business Process Overview

The Manage RI Medicaid Drug Rebate process is performed by the MMIS FI Agent, HP and overseen by the DHS Third Party Liability unit. HP receives a quarterly Drug Rebate file electronically and automatically processes invoices to all manufacturers. Reports are available for review of outstanding invoices. If adjustments are negotiated with CMS, manufacturer's can adjust invoiced amount. HP must then manually adjust invoice in MMIS.

The state only pays for drugs that have a negotiated rebate amount with CMS. If a drug manufacturer is not on the quarterly file from CMS, their drugs are blocked from payment within the MMIS.

At the time of the Current View interview, HP noted that the CMS Drug Rebate file has contained zeros for all manufacturers since March 2010. This issue results in zero

dollar amounts on the generated invoices from HP. Drug manufacturers are paying based on units reported on invoices. HP receives payment and updates invoice with paid amount. CMS has indicated that this is a resource issue and anticipates issue to be resolved in 2011.

8.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- No significant divergences were identified within the business process steps

8.1.4 Systems and Datasets

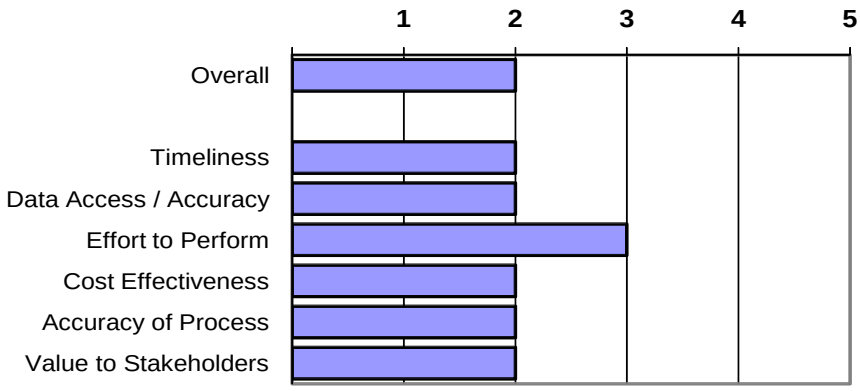
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Drug Rebate process include:

- RI-MMIS – RI Medicaid Management Information System uses data from the Recipient Eligibility, Provider, and Reference subsystems to adjudicate claims to determine claims payment.
- CMS Drug Rebate File – quarterly electronic data file sent from CMS and automatically loaded into the MMIS.

8.1.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage RI Medicaid Drug Rebate process are rated at a Level 2 with the exception of Effort to Perform which is at a Level 3 because of automation of validation rules.

Figure 27 Current Maturity Levels by Dimension: Manage RI Medicaid Drug Rebate



Examples supporting these Manage RI Medicaid Drug Rebate process ratings include the following:

- Validation is fully automated
- Drug rebate file is received electronically and automatically loaded into the MMIS
- Invoices are automatically generated for all drug manufacturers

Table 26 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Drug Rebate

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.	**2**
Data Access & Accuracy	**2**
At this level, the Manage Drug Rebate business process uses electronic interchange and automated processes; for example, magnetic tape downloads and shared drives from legacy systems support state generation of rebate information.	2
Agencies are centralizing drug utilization data from siloed programs as inputs to the drug rebate process to achieve economies of scale, increase coordination, improve rule application consistency, and standardize data to increase rebates.	**2**

MITA BCM Qualities & Characteristics	Level
Data is mostly standardized.	2
Access to data is limited by legacy systems and CMS reporting cycles. (Level 1 only)	N/A
Effort to Perform	3
Validation is fully automated.	3
Cost Effectiveness	2
Increased data accuracy and completeness creates more cost-effectiveness.	2
Accuracy of Process	2
More consistency in rule creation and application.	2
Utility or Value to Stakeholders	2
Cost management programs are implemented that bring value to stakeholders.	2

8.2 Manage RI Medicaid Estate Recovery

8.2.1 MITA Business Process

Tier 3: Manage Estate Recovery	
Item	**Details**
Description	Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution. The Manage Estate Recovery business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate lien when recovery is completed, updating Member Registry, and sending to Manage Payment History for loading. NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.

8.2.2 RI Business Process Overview

The Manage RI Medicaid Estate Recovery process is performed by the DHS Third Party Liability (TPL) unit. Estate recovery referral data is received by several sources including data of death information in InRhodes from Vital Statistics, Nursing home death notifications, manual review of probate notifications in Providence Journal, and notifications from attorneys.

The DHS legal office handles all probate manages the case. The TPL unit does have access to the legal system, PROCATS, to update case information.

8.2.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Estate recovery Questionnaire data is sent on to deceased representative (RI TPL unit manually researches eligibility and claims history information).
- Estate recovery payment receipt data is sent to the Perform Accounting Functions process and Maintain Member Information process (Recovery payment is sent to the office of the EOHHS CFO and accounted for in RI-FANS. Payment information is not sent to the MMIS or InRhodes).

8.2.4 Systems and Datasets

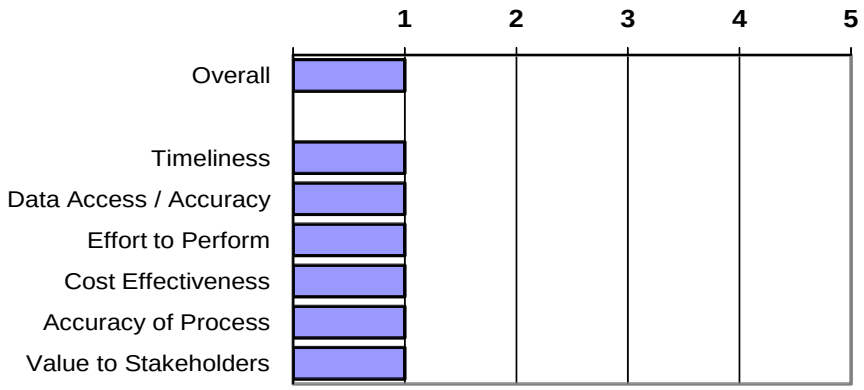
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Estate Recovery process include:

- RI-MMIS – RI Medicaid Management Information System uses data from the Recipient Eligibility, Provider, and Reference subsystems to adjudicate claims to determine claims payment.
- InRhodes - RI Eligibility system used for determination and enrollment information.
- TPL Excel Workbook – created and maintained by the DHS TPL Unit to store TPL cases.
- ASERT - TPL system linked to legal system (PROCATS) for estate recoveries.
- PROCATS – DHS legal system used for estate recoveries. Receives data from TPL system ASERT.
- RI-FANS - State's accounting system.

8.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Estate Recovery process are rated at a Level 1.

Figure 28 Current Maturity Levels by Dimension: Manage RI Medicaid Estate Recovery



Examples supporting these Manage RI Medicaid Estate Recovery process ratings include the following:

- Much of the validation is manual
- Non-standardized data and format from multiple sources requires manual compilation of data

Table 27 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Estate Recovery

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Generating correspondence is not timely.	**1**
Data Access & Accuracy	**1**
At this level the Manage Estate Recovery business process is primarily a mix of paper, phone, fax and proprietary EDI.	**1**

MITA BCM Qualities & Characteristics	Level
Non-standardized data and format from multiple sources requires manual compilation of data.	1
Access to data is limited by the sporadic, inconsistent, and untimely receipt of data and updates to member eligibility.	1
Effort to Perform	1
Information is manually validated.	1
Cost Effectiveness	1
Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing.	1
Accuracy of Process	1
Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.	1
Utility or Value to Stakeholders	1
Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing. This adversely affects the accuracy and amount of recovery which could in turn affect many stakeholders.	1

8.3 Manage RI Medicaid Recoupment

8.3.1 MITA Business Process

Tier 3: Manage Recoupment	
Item	**Details**
Description	The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer. The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the Manage Provider Communication, applying refund in the system from the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied. Recoupments can be collected via check sent by the provider or credited against future payments for services.

8.3.2 RI Business Process Overview

The Manage RI Medicaid Recoupment process is performed by the MMIS FA agent, HP, and overseen by the DHS Third Party Liability (TPL) unit. In addition to provider recoupments, HP used to perform payer recoupments. This proved to not be beneficial and is no longer pursued.

HP performs a monthly TPL cycle and identifies provider recoupments based upon a quarterly data match with HSM. The MMIS automatically calculates amount of recoupment based upon claims history and TPL coverage start date identified.

Providers are notified of recoupment and requested to send payment back to HP. When HP does receive recoupment amount from the provider, they are able to process it as a financial transaction into the appropriate state fund. HP may also deduct recoupment amount from future claims payment.

8.3.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- No significant divergences were identified within the business process steps

8.3.4 Systems and Datasets

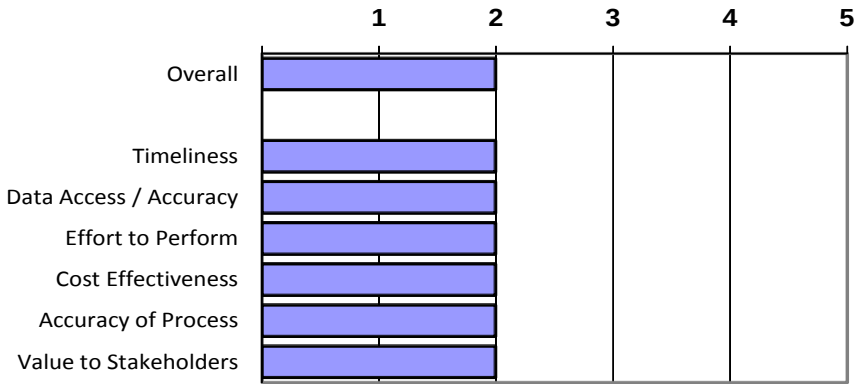
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Recoupment process include:

- RI-MMIS – RI Medicaid Management Information System uses data from the Recipient Eligibility, Provider, and Reference subsystems to adjudicate claims to determine claims payment.
- RI-MMIS TPL Subsystem - Used to support TPL staff in identification and tracking of third party payer information for Medicaid services and support recoupment efforts.
- HP DSS Profiler System – HP COTS package used for program integrity
- HMS – Health Plan Enrollment Market Share Data. A comprehensive resource available on the U.S. health plan market. It contains the most up-to-date enrollment data and contact information for health plans and primary care preferred provider networks operating in the U.S by Atlantic Information Services, Inc. (AIS)

8.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Recoupment process are rated at a Level 2.

Figure 29 Current Maturity Levels by Dimension: Manage RI Medicaid Recoupment



Examples supporting these Manage RI Medicaid Recoupment process ratings include the following:

- Monthly TPL cycles are run automatically
- MMIS calculates recoupment amount based upon claims history
- Use of the standard 837 transaction

Table 28 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Recoupment

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form (TPL monthly cycles). Timeliness exceeds legal requirement. Decisions take less time than level 1.	**2**
Data Access & Accuracy	**2**
At this level, the Manage Recoupments process is increasing its use of electronic interchange and automated processes.	**2**
There is more application-to-application communications e.g., applying refund in the system and updating payment history which results in less manual intervention resulting in less maintenance and time savings.	**3**
Some agencies are sending electronic 837s directly to other payers	**2**

MITA BCM Qualities & Characteristics	Level
More of the formatting is HIPAA compliant resulting in standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.	2
Effort to Perform	2
Most validation is automated	2
Cost Effectiveness	2
Less staff required to perform business process. Automation leads to fewer staff.	2
Accuracy of Process	2
There is an increase in coordination between the provider utilization role, recoupments and accounting resulting in rule application consistency.	2
Utility or Value to Stakeholders	2
The agency benefit from introduction of automation	2

8.4 Manage Hospital Cost Settlements

8.4.1 MITA Business Process

Tier 3: Manage Settlement	
Item	**Details**
Description	The Manage Settlement business process begins with requesting annual claims summary data from Manage Payment History, reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the Send Outbound Transaction process to Manage Provider Communication, Manage Payment History, Manage Rate Setting and sending receivables data to Perform Accounting Functions, and tracking settlement payments.

8.4.2 RI Business Process Overview

The Manage Hospital Cost Settlements process is performed by the DHS, Rate Setting unit. All in-state hospitals are required to submit annual cost reports to DHS for the cost settlement process.

Hospitals are now paid using the DRG system. The Hospital Cost Settlement process is still in place for years prior to implementing DRGs.

8.4.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Receive audited Medicare Cost Report from intermediaries (DHS receives the Medicare Cost Report directly from the hospitals).
- Establish interim reimbursement rates (DHS does not establish interim rates).

8.4.4 Systems and Datasets

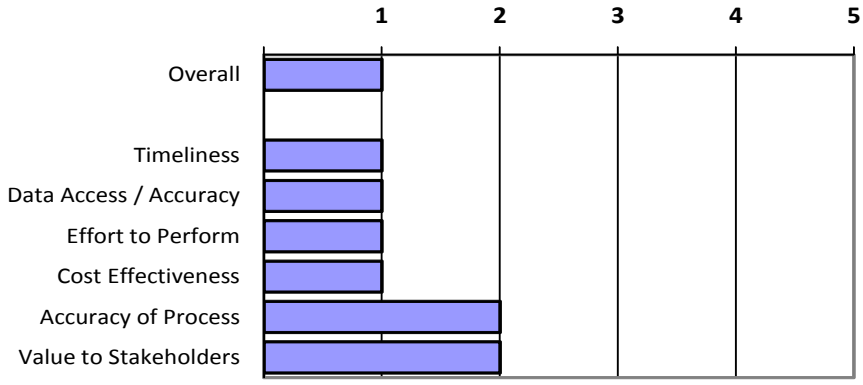
The major systems and datasets that store, transact or exchange data in support of the Manage Hospital Cost Settlements process include:

- RI-MMIS – RI Medicaid Management Information System uses data from the Recipient Eligibility, Provider, and Reference subsystems to adjudicate claims to determine claims payment.
- Cost Settlement Workbook - created and maintained by the DHS Rate Setting Unit.

8.4.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage Hospital Cost Settlements y process are rated at a Level 1 with the exception of Accuracy of Process and Value to Stakeholders rated at Level 2.

Figure 30 Current Maturity Levels by Dimension: Manage Hospital Cost Settlements



Examples supporting these Manage Hospital Cost Settlements process ratings include the following:

- Much of the validation is manual

- Non-standardized data and format from multiple sources requires manual compilation of data
- Process is well defined but lacks resources to complete

Table 29 Assessed Maturity Level by MITA Quality: Manage Hospital Cost Settlements

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions may take several days.	**1**
Data Access & Accuracy	**1**
At this level, the Manage Settlements business process is likely primarily paper based processing and some proprietary EDI.	**1**
Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting and analysis.	**2**
Effort to Perform	**1**
Information is manually validated.	**1**
Cost Effectiveness	**1**
Cost effectiveness is impacted by lack of data accuracy and completeness, and manual processing.	**1**
Accuracy of Process	**2**
More consistency in program rule application.	**2**
Utility or Value to Stakeholders	**2**
Cost management programs are implemented that bring value to stakeholders.	**2**

8.5 Manage RI Medicaid TPL Recovery

8.5.1 MITA Business Process

Tier 3: Manage TPL Recovery	
Item	**Details**
Description	The Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, SUR, Fraud and Abuse units, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History. NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.

8.5.2 RI Business Process Overview

The Manage RI Medicaid TPL Recovery process is performed by the DHS Third Party Liability (TPL) Unit. TPL data is received from a variety of sources including HMS data match, SSA data, Department of Labor for Worker's Compensation cases, DMV for auto accident cases, Katie Beckett unit within DHS for other coverage, TPL warm line and is also collected during the Medicaid eligibility determination process from applicant.

8.5.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Create post payment recovery files (the TPL unit tracks recovery information in an Excel workbook as well as a paper file).

- Receive payment from provider or third party payer (payments are sent to the EOHHS CFO office for accounting purposes. MMIS does not have any record of TPL recoveries).

8.5.4 Systems and Datasets

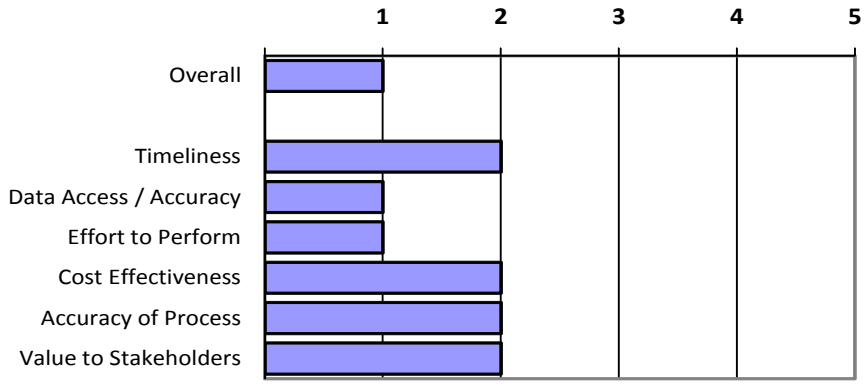
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid TPL Recovery process include:

- RI-MMIS – RI Medicaid Management Information System uses data from the Recipient Eligibility, Provider, and Reference subsystems to adjudicate claims to determine claims payment.
- InRhodes - RI Eligibility system used for determination and enrollment information.
- TPL Excel Workbook – created and maintained by the DHS TPL Unit to store TPL cases.
- RI-FANS - State's accounting system.
- SSA – CMS Medicare data for matching
- HMS - Health Plan Enrollment Market Share Data. A comprehensive resource available on the U.S. health plan market. It contains the most up-to-date enrollment data and contact information for health plans and primary care preferred provider networks operating in the U.S by Atlantic Information Services, Inc. (AIS)

8.5.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage RI Medicaid TPL Recovery process are rated at a Level 2 with the exception of Data Access / Accuracy and Effort to Perform which remain at a Level 1.

Figure 31 Current Maturity Levels by Dimension: Manage RI Medicaid TPL Recovery



Examples supporting these Manage RI Medicaid TPL Recovery process ratings include the following:

- Introduction of automated validation with SSA and HMS data matches
- Non-standardized data and format from multiple sources requires manual compilation of data
- TPL recovery is accomplished primarily via payer-to-provider COB.

Table 30 Assessed Maturity Level by MITA Quality: Manage RI Medicaid TPL Recovery

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Communications more consistent, timely, and appropriate then level 1.	**2**
Data Access & Accuracy	**1**
The Manage TPL Recoveries process uses agency specified electronic interchange and automated processes. Electronic or magnetic tape downloads from other agencies are used for data matches support access to member eligibility data.	**2**
Programs are siloed so the recovery process may be uncoordinated (Level 1 only).	**N/A**
TPL recovery is accomplished primarily via payer-to-provider COB.	**1**

MITA BCM Qualities & Characteristics	Level
Non-standardized data and format makes any type of cross program management reporting, and analysis difficult and costly.	1
Access to data is limited by inter-agency and other payer legacy systems, i.e., capability related to data matches.	1
Effort to Perform	1
Information regarding third-party resources is manually validated.	1
Cost Effectiveness	2
Automation increases accuracy and cost-effectiveness.	2
Accuracy of Process	2
More consistency in rule application.	2
Utility or Value to Stakeholders	2
The agency benefit from introduction of automation	2

9 OPERATIONS MANAGEMENT: CLAIMS PROCESSING

9.1 Apply RI Medicaid Claim Attachment

9.1.1 MITA Business Process

Tier 4: Apply Claim Attachment	
Item	**Details**
Description	This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the Edit Claim/Encounter or Audit Claim/Encounter process or has been sent by the provider (unsolicited) from the Receive Inbound Transaction process, linking it with a trace number to associated claim, stapling to a claim or pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information necessary to adjudicate the claim, and if yes, moving the attachment with claim to the next adjudication process; if no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found. NOTE: If no claim is found, the attachment data set is pended for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.

9.1.2 RI Business Process Overview

The Apply RI Medicaid Claim Attachment business process is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is contractually responsible for Medicaid attachment review and processing functions and performs the business process steps identified in the MITA framework.

The Apply Claim Attachment process for RI Medicaid is a manual process. Attachments are submitted on paper or by fax; and are scanned and maintained electronically for access by claim examiners.

9.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Electronically staple to associated claim. (RI Medicaid physically staples claim with the associated attachment(s).)
- If "no", then: a. Send requires for additional information X12 277 through the Send Outbound Transaction … (RI Medicaid does not perform this process. If the claim and attachment do not supply the necessary information, both claim and attachment are sent back to the sender. Documents are not entered into the MMIS, even to pend.)

9.1.4 Systems and Datasets

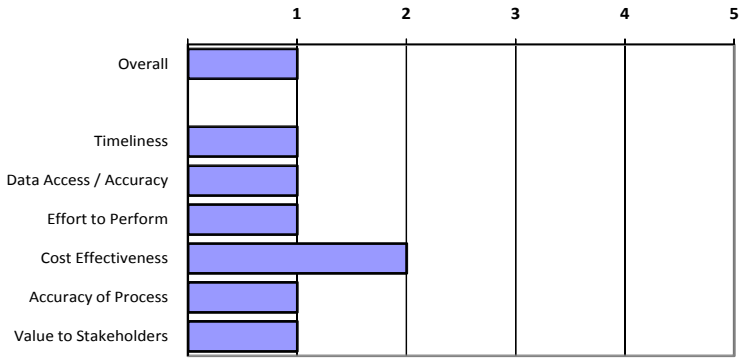
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

9.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Apply RI Medicaid Claim Attachment Business Process are rated at a Level 1capability, except for the Cost Effectiveness of the process.

Figure 32 Current Maturity Levels by Dimension: Apply RI Medicaid Claim Attachment



Examples of the qualities and characteristics that support these ratings include the following:

- Claims requiring attachments may not be paid timely
- The process is labor-intensive, requiring staff review of information
- The process is more cost effective do to the large population of Medicaid eligible's being covered under a managed care arrangement. This decreases the number of claims and attachment being processed by HP Fiscal Agent.

Table 31 Assessed Maturity Level by MITA Quality: Apply RI Medicaid Claim Attachment

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Claims requiring attachments are subject to delays.	1
Clinical information needed for adjudicating payment for a service is instantly accessed. (Level 4 Only)	N/A
Data Access & Accuracy	**1**
Medical records are delivered in paper format with no standards.	1
The agency receives a mix of paper and electronic attachments.	2

MITA BCM Qualities & Characteristics	Level
Manual matches and reviews result in inconsistency and errors.	1
State complies with HIPAA standards but also has its own IG requirements. (This does not apply to RI Medicaid)	N/A
Effort to Perform	**1**
Labor-intensive; requires professional review staff	1
More managed care enrollment means fewer claims/attachments.	2
Cost Effectiveness	**2**
Cost effectiveness increases through implementation of programs that target management of costs (managed care)	2
Accuracy of Process	**1**
There are inconsistencies in results in the manual matching and processing of attachments. Paper claim attachments are sent separately from the claim; the two documents are matched up, requiring some manual intervention.	1
Utility or Value to Stakeholders	**1**
Business process meets the stated targets of the agency.	1

9.2 Apply Void and Replace

9.2.1 MITA Business Process

Tier 4: Apply Mass Adjustment	
Item	**Details**
Description	The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly. This business process often affects multiple providers as well as multiple claims. NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.

9.2.2 RI Business Process Overview

The Apply Void and Replace business process is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is contractually responsible for the Void and Replace process at the direction of the Department, usually due to rate changes, and performs the steps identified in the MITA framework for this business process.

9.2.3 Business Process Variations

The Apply Void and Replace business process does not significantly diverge from the MITA business process definition.

9.2.4 Systems and Datasets

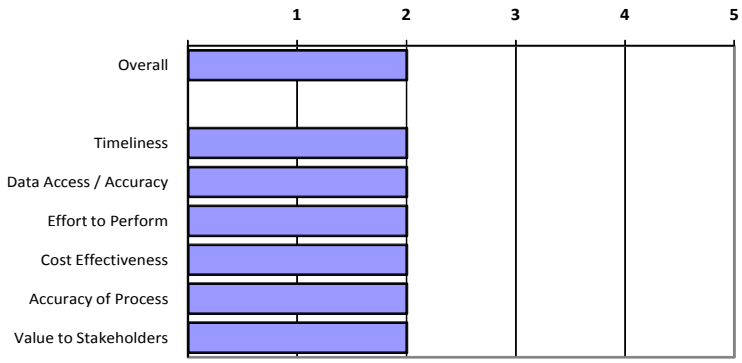
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

9.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Apply Void and Replace business process are rated at a Level 2 capability due to increased automation.

Figure 33 Current Maturity Levels by Dimension: Apply Void and Replace



Examples of the qualities and characteristics that support these ratings include the following:

- The Void and Replace process is automated and require fewer staff
- Improvements to business process has reduced the number of void and replace processes necessary
- There is more consistency and accuracy due to the automation of business rules.

Table 32 Assessed Maturity Level by MITA Quality: Apply Void and Replace

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Process is faster than Level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirements. Decisions take less time than level 1.	2
Data Access & Accuracy	**2**
Identification of claims to be adjusted and application of the adjustment are automated with audit trail.	2
Adjustment data is specific to the agency.	2
Effort to Perform	**2**
Improvements throughout the Medicaid program operations reduce the number of mass adjustments required.	2
The process has the flexibility to easily change the criteria for identification of claims and application of the adjustment. (Level 3 Only)	N/A
Other agencies that might be affected by the mass adjustment collaborate with the Medicaid agency. (Level 3 Only)	N/A
Cost Effectiveness	**2**
Less staff required to perform business process. Automation leads to fewer staff.	2
Accuracy of Process	**2**
More consistency in rule creation and application	2
Utility or Value to Stakeholders	**2**
The agency benefits from introduction of automation.	2

9.3 Calculate Medical Needy Spend-Down Amount

9.3.1 MITA Business Process

Tier 3: Calculate Spend-Down Amount	
Item	**Details**
Description	A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called "spend-down" (see Determine Eligibility). The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. Excess resources are automatically accounted for during the claims processing process resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations. The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data. Once the eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. NOTE: The 'Calculate Spend-down Amount' today is primarily a manual process in the Eligibility Determination, Member Payment Management and Maintain Payment History threads. At Level 3 these processes have almost eliminated any use of manual intervention.

9.3.2 RI Business Process Overview

Medically needy eligible individuals may be responsible for a portion of their medical expenses through the spend-down process. The Department of Human Services' eligibility workers determine initial eligibility and the spend-down obligation for these members. InRhodes serves as an accumulator of claims that apply toward the spend-down amount.

Once individuals become eligible by meeting their spend-down obligation, Medicaid pays the claims that were not applied to the spend-down for that certification period.

Cases that have a spend-down obligation met have information passed from InRhodes to the MMIS. InRhodes notifies the DHS that the client is eligible for Medicaid.

9.3.3 Business Process Variations

The Calculate Medically Needy Spend-Down Amount business process does not significantly diverge from the MITA business process definition.

9.3.4 Systems and Datasets

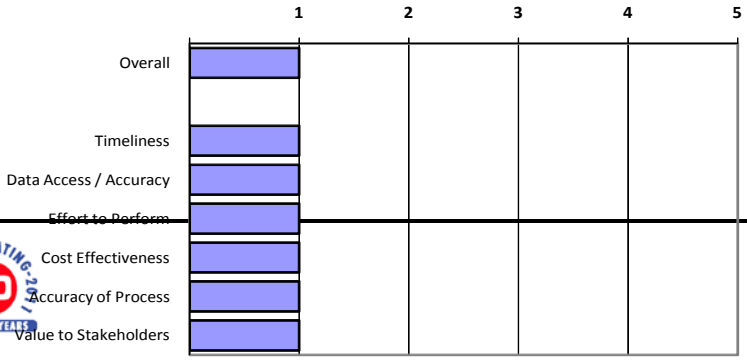
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- InRhodes - RI Eligibility system used for determination and enrollment information.
- RI MMIS - used by providers for recipient eligibility verification; check the status of a submitted claim; check the status of a prior authorization request; pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program; confirm their Medical Assistance payment history for the last 12 months; and view their Remittance Advice (RA) electronically in the paper RA format.

9.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Calculate Medically Needy Spend-Down Amount process are rated at a Level 1.

Figure 34 Current Maturity Levels by Dimension: Calculate Medically Needy Spend-Down Amount



Examples supporting these Calculate Medically Needy Spend-Down Amount process ratings include the following:

- Members are required to submit proof of payment of medical claims to the Eligibility Worker
- Eligibility Worker's must key updates to Spend-Down manually
- Although the X12 270-271 supports transmission of spend down information, RI Medicaid does not take advantage of this capability.

Table 33 Assessed Maturity Level by MITA Quality: Calculate Medically Needy Spend-Down Amount

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	**1**
The Calculate Spend-Down Amount business process is primarily paper based. An applicant's costs for health services are tracked by adding paper bills and receipts until the spend-down amount for each period is met.	1
Applicants may be required to submit a paper spend-down report.	1
If spend-down is met, staff keys change in eligibility status into the applicant's record so that subsequent claims will pay for a specified period.	1
Although the X12 270-271 supports transmission of spend down information, this purpose is not mandated by HIPAA. (RI does not perform this function)	N/A
Effort to Perform	**1**
Updates are completed (keyed) manually.	1
Cost Effectiveness	
Large number of staff required to perform business process. (Relative to RI)	1

MITA BCM Qualities & Characteristics	Level
Accuracy of Process	**1**
Staff applies spend down rules to decide whether the submitted costs are allowable and in which period to apply the costs, sometimes resulting in inconsistent determinations or controversy with the applicant.	1
Utility or Value to Stakeholders	**1**
Focus is on conducting business functions as efficiently as possible.	1

9.4 Edit and Audit RI Medicaid Encounter

9.4.1 MITA Business Process

Tier 4: Audit Claim/Encounter	
Item	**Details**
Description	The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the Price Claim/Value Encounter process All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.
Tier 4: Edit Claim/Encounter	
Item	**Details**
Description	The Edit Claim/Encounter business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and ■ Determines its submission status ■ Validates edits, service coverage, TPL, coding ■ Populates the data set with pricing information Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This business process is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, and Prepare Remittance Advice/Encounter processes. NOTE: The Edit Claim/Encounter process does not apply to: — Point of Sale, which requires that Edit, Audit, and other processes be integrated, or — Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.

9.4.2 RI Business Process Overview

The Edit and Audit RI Medicaid Encounter business process is overseen by the Department of Human Services' Claim Unit. The MMIS Fiscal Agent, HP, is contractually responsible for Medicaid encounter edit and audit functions and performs the business steps identified in the MITA framework for this business process.

This process has its own distinct set of functions from those separately assessed for Edit and Audit RI Medicaid Claim, which also maps to the Edit and Audit Claim/Encounter MITA business process.

9.4.3 Business Process Variations

The following are examples of elements in this Medicaid business process that diverge from the MITA definition of Edit Claim/Encounter:

- A service is covered but the member is enrolled in another payer … so flag as pay-and-chase in order that the provider will be paid and a pay-and-chase COB claims will be sent to the primary payer. (Not applicable to RI Medicaid Managed Care.)
- Populate claim data set with state allowed payment amount. (Not applicable to RI Medicaid Managed Care.)
- Validate appropriateness of service codes including correct association of services with diagnosis and member demographic and health status (RI Medicaid does not perform this function on encounter data)
- Validate correct coding; apply DRG or APC Groupers; and bundle or unbundled codes (Not applicable for encounter data)
- Populate claim data set with state allowed payment amount (This information comes in on the encounter files from the health plans)

The following are examples of elements in this Medicaid business process that diverge from the MITA definition of Audit Claim/Encounter:

- Check Payment History Repository for Life Time Limits for services, cost, and units (Not applicable to encounter data)
- Check clinical appropriateness of the services provided based on clinical, case and disease management protocols (This is not performed for encounter data)
- Perform Prospective Payment Integrity Check (This is not performed for encounter data)

9.4.4 Systems and Datasets

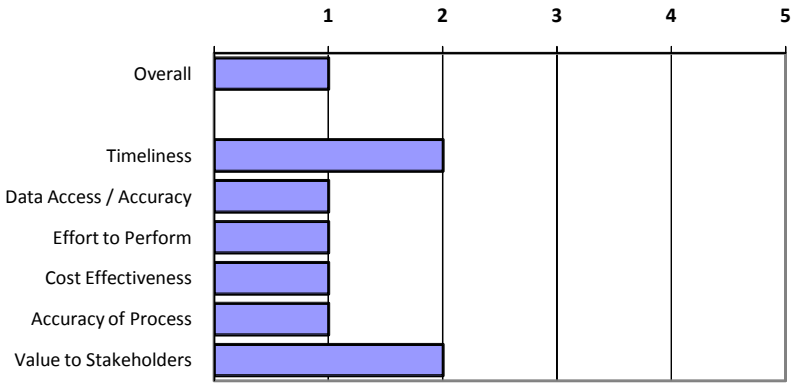
The major systems and datasets that store, transact or exchange data in support of the Edit and Audit Claim/Encounter process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

9.4.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Edit and Audit RI Medicaid Encounter process are rated at a Level 1 with the exception of timeliness and value to stakeholders, which are at a level 2 maturity.

Figure 35 Current Maturity Levels by Dimension: Edit and Audit Standard RI Medicaid Encounter



Examples of the qualities and characteristics that support these ratings include the following:

- Encounter submissions by health plans are electronic only.
- Edits are conducted at a high-level only, such as to validate member eligibility and not validate data content.

Table 34 Assessed Maturity Level by MITA Quality: Edit and Audit RI Medicaid Encounter

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Electronic claim processing and POS adjudication greatly increase timeliness.	2
Data Access & Accuracy	**1**
The agency continues to accept paper claims from a small number of disadvantaged providers, but the majority of transactions are submitted electronically. (All encounter data is received quarterly electronically)	3
Claims/encounter EDI format and content is not HIPAA compliant.	1
Translators convert national data standards to state-specific data to support business processes.	2

MITA BCM Qualities & Characteristics	Level
Encounter data is received electronically or is posted to Web sites and uses state specified, non-HIPAA-compliant formats.	2
Medicaid agency can accept sister agency and waiver program claims and load other agency data into an enterprise data warehouse by supporting multiple formats and mapping non-standard data elements.	2
As a result, data are not comparable across silos. (N/A)	N/A
All programs, even those not covered under HIPAA, use semantically interoperable data in the edit process. (Level 3 Only)	N/A
Attachment data is unstructured; it is difficult for reviewers to consistently interpret and apply adjudication rules.	1
Effort to Perform	**1**
For EDI claims/encounters, edits are automated for many steps, but are manual for attachments and suspended claims/encounters	1
Inflexibility in Edit processing is a key factor in the proliferation of siloed payment systems outside of the MMIS, especially for waiver programs that determine member eligibility, enroll providers and pay for services differently than traditional Medicaid programs.	1
As a result, all siloed payment systems are integrated or retired, saving resources and optimizing FFP; and data quality is improved. (Level 3 Only)	N/A
COB is conducted by denying claims using the resource intensive payer-to-provider model. (RI Medicaid does not perform this function)	N/A
Although data is electronic, much of the review and verification of information must be done manually.	2
If additional information is required, an electronic request is made, e.g., via an X12 277. (RI Medicaid does not perform this function)	N/A
The Edit process, using repository meta-data in the registry records, is also able to locate and query the members' Clinical data to validate health status data in order to ensure the appropriate coding of services and reduce the need for suspending claims/ encounters for additional information. (Level 4 Only)	N/A
In addition, the Edit process can locate members' primary payers' benefit repository, using pointers in the members' records, to access services covered under each third party resource, thereby validating service coverage to conduct COB more efficiently. (Level 4 Only)	N/A
Cost Effectiveness	**1**
Maintenance continues to be expensive and time-consuming	2

MITA BCM Qualities & Characteristics	Level
Rules lack flexibility and are costly to change. Therefore, when new programs, code sets, or edits are added, claims/encounters with these changes may need to be edited manually, which may not be cost effective in the long term.	1
Accuracy of Process	**1**
Results meet agency requirements for timeliness and accuracy.	1
Despite progress, related processes continue to be tightly integrated, so that changes to edits can result in unintended downstream processing consequences.	2
The Edit Claim/Encounter process is completely automated and only rare edit exceptions must be manually reviewed. (Level 3 Only)	N/A
Optimizing automation improves error rates and timeliness, thereby enabling support of real-time claims/encounter processing. (Level 3 Only)	N/A
Utility or Value to Stakeholders	**2**
This increases the number of small providers who can submit electronically.	2

9.5 Edit and Audit RI Medicaid Claim

9.5.1 MITA Business Process

Tier 4: Audit Claim/Encounter	
Item	**Details**
Description	The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity a Suspends data sets that fail audits for internal review, corrections, or additional information Sends successfully audited data sets to the Price Claim/Value Encounter process All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This E2E is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter processes.
Tier 4: Edit Claim/Encounter	
Item	**Details**
Description	The Edit Claim/Encounter business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and ■ Determines its submission status ■ Validates edits, service coverage, TPL, coding ■ Populates the data set with pricing information Sends validated data sets to Audit Claim/Encounter process and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints. NOTE: This business process is part of a suite that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, and Prepare Remittance Advice/Encounter processes. NOTE: The Edit Claim/Encounter process does not apply to: — Point of Sale, which requires that Edit, Audit, and other processes be integrated, or — Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.

9.5.2 RI Business Process Overview

The Edit and Audit RI Medicaid Claim business process is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is contractually responsible for Medicaid claims edit and audit functions and performs the steps identified in the MITA framework for this business process.

On average, 85-90% of claims are submitted electronically for adjudication. The remaining 10-15% of claims are a mix of paper claims and check requests from the DHS utilizing the FACN process (Fiscal Agent Control Notice). Claims as a result of Medicaid services provided by programs administered by the BHDDH, DEA and DCYF (including CNOMS) are also processed by the MMIS and are included in the 85-90% of electronic claims measurement.

9.5.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- A service is covered but the member is enrolled in another payer … so flag as pay-and-chase in order that the provider will be paid and a pay-and-chase COB claims will be sent to the primary payer. (RI Medicaid does not perform this process)
- Populate claim data set with state allowed payment amount. (For RI Medicaid this is performed during the Price Claim/Value Encounter process)
- Check Payment History Repository for Life Time Limits for services, cost and units (Step performed. Moved from the MITA Audit Claim/Encounter business process).
- For Claims: Verify Authorized Service (Step performed. Moved from the MITA Audit Claim/Encounter business process).

- Perform Prospective Payment Integrity Check (Step performed utilizing "Claim Check" software. Moved from the MITA Audit Claim/Encounter business process).

9.5.4 Systems and Datasets

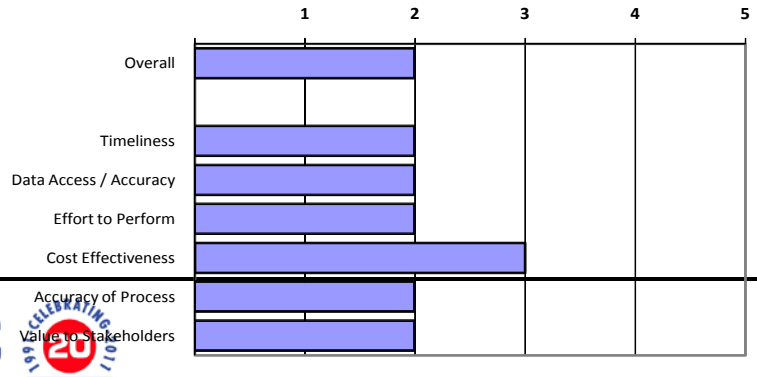
The major systems and datasets that store, transact or exchange data in support of the Edit and Audit RI Medicaid Claim process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- PES – Provider Electronic Solutions. Free software provided to Medical Assistance Program providers that enables them to submit Institutional, Professional and Dental claims electronically. It also allows them to receive RAs electronically.

9.5.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Edit and Audit RI Medicaid Claim process are rated at a Level 2 with the exception of Cost Effectiveness, which are at a level 3 maturity.

Figure 36 Current Maturity Levels by Dimension: Edit and Audit Medicaid Claim



Examples of the qualities and characteristics that support these ratings include the following:

- Over 90% of all FFS claims, with the exception of dental, are received electronically
- Claims formats are HIPAA compliant but some EDI data content is not HIPAA compliant
- Editing and auditing of claims requires a mixture of automated and manual processes (i.e. some claims suspend for manual review and validation).

Table 35 Assessed Maturity Level by MITA Quality: Edit and Audit RI Medicaid Claim

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Electronic claim processing and POS adjudication greatly increase timeliness.	2
Data Access & Accuracy	**2**
The agency continues to accept paper claims, but most providers submit claims via Web portals, email, dial-up, POS, and EDI.	2
Electronic transactions meet HIPAA data standards. Payer Implementation Guides impose additional payer-specific rules.	2
Translators convert national data standards to state-specific data to support business processes.	2
Encounter data is received electronically or is posted to Web sites and uses state specified, non-HIPAA-compliant formats.	2
Medicaid agency can accept sister agency and waiver program claims and load other agency data into an enterprise data warehouse by supporting multiple formats and mapping non-standard data elements.	2
Waiver claims continue to be submitted to siloed payment systems	N/A
All programs, even those not covered under HIPAA, use semantically interoperable data in the edit process. (Level 3 Only)	N/A

MITA BCM Qualities & Characteristics	Level
Attachment data is unstructured; it is difficult for reviewers to consistently interpret and apply adjudication rules. (Level 1 only).	N/A
Effort to Perform	**2**
If a claim/encounter data set fails edit validation, the process can now generate an electronic request for corrections via an X12/276	2
Inflexibility in Edit processing is a key factor in the proliferation of siloed payment systems outside of the MMIS, especially for waiver programs that determine member eligibility, enroll providers and pay for services differently than traditional Medicaid programs. (Level 1 only).	N/A
As a result, all siloed payment systems are integrated or retired, saving resources and optimizing FFP; and data quality is improved.	3
COB is conducted by denying claims using the resource intensive payer-to-provider model. (RI Medicaid does not perform this function)	N/A
Although data is electronic, much of the review and verification of information must be done manually.	2
If additional information is required, an electronic request is made, e.g., via an X12 277. (RI Medicaid does not perform this function)	N/A
The Edit process, using repository meta-data in the registry records, is also able to locate and query the members' Clinical data to validate health status data in order to ensure the appropriate coding of services and reduce the need for suspending claims/ encounters for additional information. (Level 4 Only)	N/A
In addition, the Edit process can locate members' primary payers' benefit repository, using pointers in the members' records, to access services covered under each third party resource, thereby validating service coverage to conduct COB more efficiently. (Level 4 Only)	N/A
Cost Effectiveness	**3**
Due to increased efficiency, staff can be redirected to more productive tasks.	3
Rules lack flexibility and are costly to change. Therefore, when new programs, code sets, or edits are added, claims/encounters with these changes may need to be edited manually, which may not be cost effective in the long term. Level 1 only).	N/A
Accuracy of Process	**2**
Results meet agency requirements for timeliness and accuracy. (Level 1 only)	N/A
Despite progress, related processes continue to be tightly integrated, so that changes to edits can result in unintended downstream processing consequences.	2
The Edit Claim/Encounter process is completely automated and only rare edit exceptions must be manually reviewed.	3

MITA BCM Qualities & Characteristics	Level
Optimizing automation improves error rates and timeliness, thereby enabling support of real-time claims/encounter processing.	3
Utility or Value to Stakeholders	**2**
This increases the number of small providers who can submit electronically.	2

9.6 Inquire RI Medicaid Payment Status

9.6.1 MITA Business Process

Tier 3: Inquire Payment Status	
Item	**Details**
Description	The Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set via the Send Outbound Transaction process.

9.6.2 RI Business Process Overview

The Inquire RI Medicaid Payment Status business process is performed by the MMIS Fiscal Agent, HP, Claim's Unit. HP is contractually responsible for providing the operational support and tools necessary for performing this business process.

9.6.3 Business Process Variations

The Inquire RI Medicaid Payment Status business process does not significantly diverge from the MITA business process definition.

9.6.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

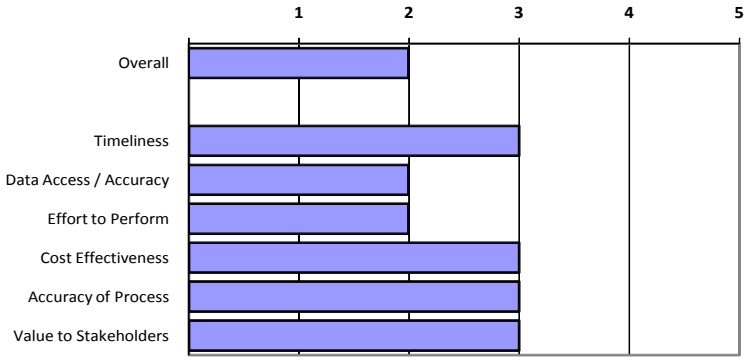
- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

- Interactive Web Services – used by providers for recipient eligibility verification; check the status of a submitted claim; check the status of a prior authorization request; pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program; confirm their Medical Assistance payment history for the last 12 months; and view their Remittance Advice (RA) electronically in the paper RA format.

9.6.5 Maturity Characteristics

As shown in the graphic and table that follows, many of the aspects of the Inquire RI Medicaid Payment Status business process are rated at a Level 3 capability due to the integration of automated support tools. The process is efficient and timely.

Figure 37: Current Maturity Levels by Dimension: Inquire RI Medicaid Payment Status



Examples of the qualities and characteristics that support these ratings include the following:

- Process time is immediate for providers utilizing the internet or through Interactive Web Services
- Less staff is required to respond to inquiries due to the availability of automated responses

Table 36: Assessed Maturity Level by MITA Quality: Inquire RI Medicaid Payment Status

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**3**
Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness.	3
Data Access & Accuracy	**2**
Program employs AVR, legacy direct data entry, and point of service devices for electronic claims status responses. Staff may still manually handle inquiries that are not resolved with automated response.	2
Interfaces use MITA standards. Providers sent HIPAA X12 276 or use online direct data entry and receive HIPAA X12 277 response or find the claim status online. (Level 3 only)	N/A
Staff performs search on the claims history data store (for claims in process) or the claims history repository for claims that have been adjudicated. Search may be based on the claim ICN, date of service, or patient name. (This is a level 1 rating only. Automated tools are available to support claim status inquiries)	N/A
Effort to Perform	**2**
Updates are automatically processed.	2
Cost Effectiveness	**3**
Further reduction of staff required to perform business process.	3
Accuracy of Process	**3**
Consistency and predictability of the process. Rules are consistently applied. Decisions are uniform.	3
Utility or Value to Stakeholders	**3**
Stakeholders experience seamless and efficient program communications no matter how or where they contact the Agency.	3

9.7 Price RI Medicaid Claim

9.7.1 MITA Business Process

Tier 4: Price Claim/Value Encounter	
Item	**Details**
Description	The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the Manage Payment History process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic. NOTE: An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.

9.7.2 RI Business Process Overview

The Price RI Medicaid Claim business process is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is contractually responsible for Medicaid claims pricing functions (including claims for services administered by BHDDH, DCYF, and DEA) and performs the business steps identified in the MITA framework for this business process.

9.7.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Price Diagnosis Related Grouping(s) (DRGs) or Ambulatory Patient Classification(s) (APCs) based on contracted rates. (Only applicable to

Hospitals. RI Medicaid reimbursement for all other provider types is based on a Ratio of Cost to Charge)

9.7.4 Systems and Datasets

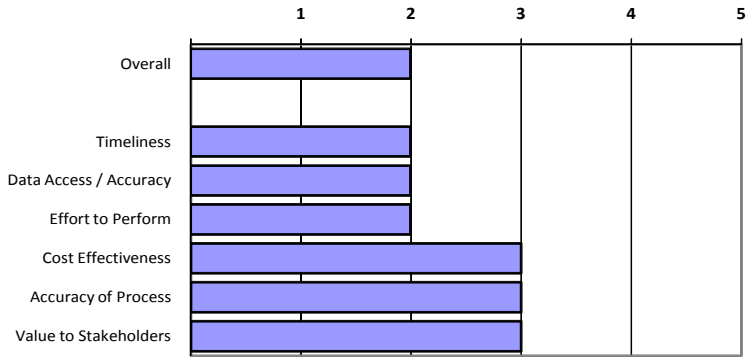
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

9.7.5 Maturity Characteristics

As shown in the graphic and table that follows, aspects of the Price RI Medicaid Claim business process are rated at Level 2 and 3 capabilities.

Figure 38 Current Maturity Levels by Dimension: Price RI Medicaid Claim



Examples of the qualities and characteristics that support these ratings include the following:

- Automation improves processing time

- Most services are automatically priced with some exceptions that need manual intervention
- Less staff required to perform the business process

Table 37 Assessed Maturity Level by MITA Quality: Price RI Medicaid Claim

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.	2
Data Access & Accuracy	**2**
Adjustment process (TBD). (Level 4 Only – incomplete MITA framework)	N/A
Pricing formulas are agency-specific	2
Values are assigned to services reported on encounters, using the same reference data. (RI Medicaid does not currently value encounter data)	NA
More services are automatically priced and there are fewer "by-report" manual pricing exceptions.	2
State Medicaid agency can support payment of waiver program and a-typical providers.	2
Effort to Perform	**2**
Most single claim adjustments are automated.	2
Cost Effectiveness	**3**
Further reduction of staff required to perform business process	3
Accuracy of Process	**3**
Flexible business rules allow maximum flexibility in changing pricing algorithms.	3
Utility or Value to Stakeholders	**3**
Agency benefits from sharing of the business service and information with other agencies.	3

9.8 Prepare Recipient Explanation of Member Benefits

9.8.1 MITA Business Process

Tier 4: Prepare EOB	
Item	**Details**
Description	The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims. This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the Explanation of Benefits (EOBs) and/or notification letters, formatting the data into the required data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication. NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.

9.8.2 RI Business Process Overview

The Prepare Medicaid Recipient Explanation of Member Benefits (REOMB) (also known as an Explanation of Benefits) is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is responsible for identifying sample data using random sampling methodology and performing the steps identified in the business process. The REOMBs are sent to the recipients within 45 days of the service.

9.8.3 Business Process Variations

The Prepare Recipient Explanation of Member Benefits business process does not significantly diverge from the MITA business process definition.

9.8.4 Systems and Datasets

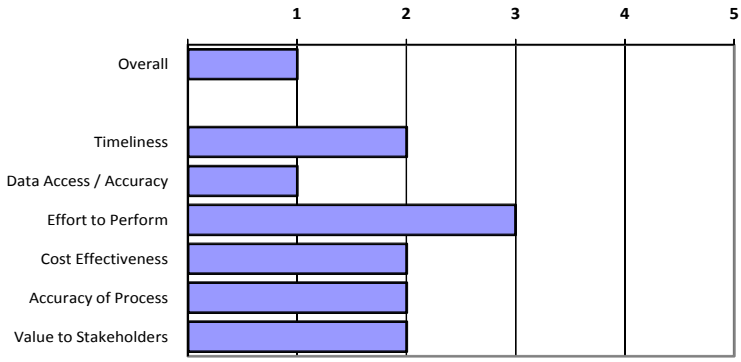
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

9.8.5 Maturity Characteristics

As shown in the graphic and table that follows, most of the Prepare Recipient Explanation of Member Benefits process is rated at levels 2 and 3, but has an overall Level 1 capability due to data access and accuracy capability still being rated at level 1.

Figure 39 Current Maturity Levels by Dimension: Prepare Recipient Explanation of Member Benefits



Examples of the qualities and characteristics that support these ratings include the following

- RI Medicaid complies with federal regulations to produce REOMBs quarterly, through a random sampling process, and mail them to members; however, REOMB sometimes are directed at targeted populations

- Although the REOMB generation process is automated, compilation of responses is labor-intensive.

Table 38 Assessed Maturity Level by MITA Quality: Prepare Recipient Explanation of Member Benefits

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.	2
Data Access & Accuracy	**1**
Medicaid agency enhances the sampling process to targeted populations.	2
Members are asked to read the REOMB and report on any discrepancies.	1
Sensitive services are suppressed.	1
Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.	2
Effort to Perform	**3**
All EOB is coordinated among data sharing partner agencies in the state.	3
Cost Effectiveness	**2**
Maintenance of REOMB processes continues to be labor intensive.	2
Accuracy of Process	**2**
Automation improves error rates.	2
Utility or Value to Stakeholders	**2**
Cultural and linguistic adaptations are introduced.	2
Cost management programs are implemented that bring value to stakeholders: i.e., members enrolled in managed care and PCP programs receive better attention for preventive care and treatment.	2

9.9 Prepare RI Medicaid Provider / Premium EFT

9.9.1 MITA Business Process

Tier 4: Prepare Provider EFT/Check	
Item	**Details**
Description	The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including: ■ Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the Manage 1099 process ■ Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues ■ Dispersement of payment from appropriate funding sources per Agency Accounting and Budget Area rules ■ Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities] ■ Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction ■ Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history ■ Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS

Tier 4: Prepare Premium EFT/Check	
Item	**Details**
Description	The Prepare Premium Capitation EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including ■ Calculation of — HIPP premium based on members' premium payment data in the Contractor Registry — Medicare premium based on dual eligible members' Medicare premium payment data in the Member Registry — PCCM management fee based on PCCM contract data re: difference reimbursement arrangements in the Contractor Registry — MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor Registry — Stop-loss claims payments for MCOs in the Contractor Registry ■ Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives ■ Dispersement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules ■ Associate the MCO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities] ■ Routing the payment per the Contractor Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction ■ Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate

9.9.2 RI Business Process Overview

The Prepare RI Medicaid Provider/Premium EFT process is performed by MMIS Fiscal Agent, HP, Financial Unit. In 2009 DHS mandated EFT for the Rhode Island Medical

Assistance Program. Only in rare cases, such as with the Rhode Island Public Transportation Authority (RIPTA) is a paper check issued.

The actual production of the EFT is handled by Bank of America. The MMIS Fiscal Agent, HP, is responsible for maintaining the EFT file produced from the MMIS Financial Subsystem and the transmission to Bank of America who disperses the funds to the provider accounts once the RI State Controller's Office deposits funds to the disbursement account.

9.9.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- For payroll processing, perform tax withholds and generate data for accounting (Tax withholds are reported on the 1099)
- Disperse funds as specified by the Agency Accounting and Budget Area rules (This function is performed by Bank of America)

9.9.4 Systems and Datasets

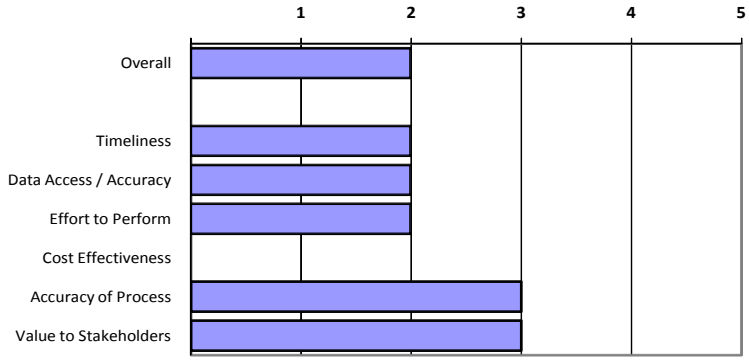
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- RI-FANS – RI State's integrated financial management system.

9.9.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Prepare RI Medicaid Provider / Premium EFT process are rated at a Level 2 capability, with the exception of Accuracy of Process and Value to Stakeholder, which are rated a Level 3 capability.

Figure 40 Current Maturity Levels by Dimension: Prepare RI Medicaid Provider/Premium EFT



Examples of the qualities and characteristics that support these ratings include the following:

- 99% of all Medicaid-related payments are conducted via EFT.
- Subsystem maintains the capability to modify and be responsive to changing financial reporting needs
- EFT process is standardized across the State.

Table 39 Assessed Maturity Level by MITA Quality: Prepare RI Medicaid Provider / Premium EFT

MITA BCM Qualities & Characteristics	Level
OVERALL	2
Timeliness	2

MITA BCM Qualities & Characteristics	Level
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than level 1.	2
Data Access & Accuracy	**2**
Medicaid agency complies with state or industry standards for EFT transactions and conforms with HIPAA where appropriate. Agency Encourages electronic billers to adopt EFT payment. (RI Medicaid is moving towards a level three maturity in that all Medicaid providers are required to accept EFT)	2
All electronic billers receive EFT payment. Through inter-agency coordination, multiple agencies share the same EFT process.	3
Effort to Perform	**2**
Verification is mostly automated.	2
Cost Effectiveness	**N/A**
Maintenance of EOB processes continues to be labor intensive. (Does not apply to EFT process)	N/A
Accuracy of Process	**3**
The agency has the flexibility to easily change the business rules.	3
Utility or Value to Stakeholders	**3**
Agencies benefit from sharing the business service and information with other agencies.	3

9.10 Prepare RI Medicaid Remittance Advice

9.10.1 MITA Business Process

Tier 4: Prepare Remittance Advice/Encounter Report	
Item	**Details**
Description	The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the pricing, audit and edit processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading. NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.

9.10.2 RI Business Process Overview

The Prepare RI Medicaid Remittance Advice process (also known as an Explanation of Benefits) is overseen by the Department of Human Services' Claims Unit. The MMIS Fiscal Agent, HP, is responsible for generating remittance advices after claims are processed and the Financial Cycle is complete. Remittance advices are available for download by the Submitter who has been identified by the RI Medicaid Provider as the Entity who will be authorized to retrieve their Remittance transactions. Paper remittance advices are no longer sent.

9.10.3 Business Process Variations

The Prepare RI Medicaid Remittance Advice business process does not significantly diverge from the MITA business process definition.

9.10.4 Systems and Datasets

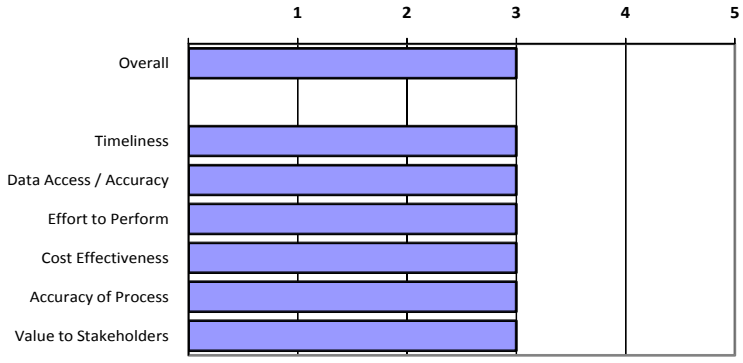
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- Interactive Web Services – used by providers for recipient eligibility verification; check the status of a submitted claim; check the status of a prior authorization request; pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program; confirm their Medical Assistance payment history for the last 12 months; and view their Remittance Advice (RA) electronically in the paper RA format.

9.10.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Prepare RI Medicaid Remittance Advice process is rated at a Level 3 capability.

Figure 41 Current Maturity Levels by Dimension: Prepare RI Medicaid Remittance Advice



Examples of the qualities and characteristics that support these ratings include the following:

- Paper remittance advice are not longer mailed to providers
- HP posts the ASC X12 835 to the internet for download by providers
- The entire process is automated. Very little to no manual intervention is needed for this process

Table 40 Assessed Maturity Level by MITA Quality: Prepare RI Medicaid Remittance Advice

MITA BCM Qualities & Characteristics	Level
OVERALL	**3**
Timeliness	**3**
Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness. Turnaround time can be immediate. ("Immediate" is relative to the payment cycle and the availability of the information in a more immediate manner due to EDI and EFT processes	3
Data Access & Accuracy	**3**
The agency uses MITA Standard interfaces for the RA. Paper RAs are still supported on an exception basis. (All providers receive electronic RA.)	3
The RA itemizes the services that are covered in the payment and explains which services are not being paid or are being changed and the reason why. Explanations of codes are comprehensive and agency-specific. (HIPAA Standard RA codes are being utilized)	N/A
All electronic billers receive ERAs. (All RI providers receive an electronic RA.)	3
Through inter-agency coordination, multiple agencies can use the same ERA data standard.	3
Effort to Perform	**3**
Verification is fully automated and immediate. Automated verification and application response are real time. (The whole RA process is automated. Paper RAs are no longer sent by mail)	3
Cost Effectiveness	**3**
Further reduction of staff required to perform business process.	3
Accuracy of Process	**3**

MITA BCM Qualities & Characteristics	Level
Rules are consistently applied.	3
Utility or Value to Stakeholders	**3**
Agencies benefit from sharing of the business service and information with other agencies.	3

10 OPERATIONS MANAGEMENT: PREMIUM PAYEMENTS

10.1 Prepare Capitation Premium Payment

10.1.1 MITA Business Process

Tier 4: Prepare Capitation Premium Payment	
Item	**Details**
Description	The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Maintain Member Information, retrieving the rate data associated with the plan from the Manage Provider Information, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Manage Provider Information for updating. NOTE: This process does not include sending the capitation payment data set.

10.1.2 RI Business Process Overview

The Prepare Capitation Premium Payment business process is performed by the MMIS Fiscal Agent's, HP, Financial Unit. Bank of America, RI Medicaid's bank, is ultimately responsible for conducting the EFT process and dispersing funds to the Managed Care Organization accounts once the RI State Controller's Office deposits funds to the disbursement account. The HP Financial Unit is responsible for initiating premium capitation payments for Medicaid Managed Care Plans.

10.1.3 Business Process Variations

The following are examples of elements in this Medicaid business process that diverge from the MITA definition:

- Retrieve benefit transaction data (Benefit transaction data is not used for this process. Program code, recipient count, plan, and month are used by the Financial Unit for preparing capitation premiums)
- Concatenate rate totals if sending summary premium payment (Not applicable to RI).

10.1.4 Systems and Datasets

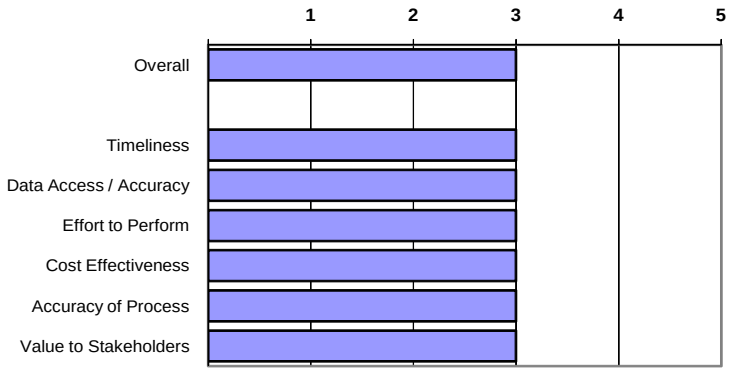
The major systems and datasets that store, transact or exchange data in support of the Capitation Premium Payment process include:

- InRhodes – RI Eligibility system used for determination and enrollment information.
- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

10.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Prepare Capitation Premium Payment Business Process are rated at a Level 3 capability. The Prepare Capitation Premium Payment Business Process is performed mostly with automation.

Figure 42 Current Maturity Levels by Dimension: Prepare Capitation Premium Payment



Examples of the qualities and characteristics that support these ratings include the following:

- The capitation premium payment process is mostly automated
- Process utilizes the HIPAA standard X12 820 Premium Payment transaction.
- Less staff required to perform business process due to increased automation.

Table 41 Assessed Maturity Level by MITA Quality: Prepare Capitation Premium Payment

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**3**
Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness. Turnaround time can be immediate.	3
Data Access & Accuracy	**2**
At level 2, capitation payments are automatically produced and conform to HIPAA standards. Some transactions continue to be manually processed at the request of the other insurer. (Capitation payments are all made via the X12 820 transaction and the actual dollars are by EFT)	2

MITA BCM Qualities & Characteristics	Level
The agency implements HIPAA-compliant standards for electronic premium payments, however, the other insurance companies impose their specific Implementation Guide requirements. (The later part of this statement is not true for RI)	2
Clinical information is accessed directly from the MCO/PCP if the capitation payment is supplemented for special circumstances, e.g., high risk pregnancy. (Level 4 only)	N/A
Effort to Perform	**3**
The agency has the flexibility to easily change the criteria for rate cells.	3
Cost Effectiveness	**3**
Further reduction of staff required to perform business process.	3
Accuracy of Process	**3**
Rules are consistently applied.	3
Utility or Value to Stakeholders	**3**
Agencies benefit from sharing of the business service and information with other agencies.	3

10.2 Prepare Rite Share Premium Payment

10.2.1 MITA Business Process

Tier 4: Prepare Health Insurance Premium Payment	
Item	**Details**
Description	Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers. The Process Health Insurance Premium Payments business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain Member Information for updating. NOTE: This process does not include sending the health insurance premium payment data set.

10.2.2 RI Business Process Overview

RIte Share is Rhode Island's Premium Assistance Program that helps Rhode Island families afford health insurance through their employer by paying for some or all of the employee's cost. The program is overseen by the Department of Human Services' Center for Child and Family Health. The MMIS Fiscal Agent, HP, is responsible for producing an EFT file based upon the RIte Share program indicator in the Eligibility Subsystem. The EFT file is sent electronically to the State's banking entity, Bank of America, as well as the HP print center for any manual checks to be printed. In most circumstances, the state pays the member's premium payment directly to the employer.

10.2.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Start: Receive referral information (This is done by receiving an application from the applicant.)
- Check internal and external eligibility information (This is performed during the Determine Eligibility business process.)
- Edit Eligibility information (This is performed during the Manage Member Information.)
- Produce report identifying individuals where paying premiums would be cost effective. (Not performed by RI.)
- Product member notifications (Not performed by RI.)

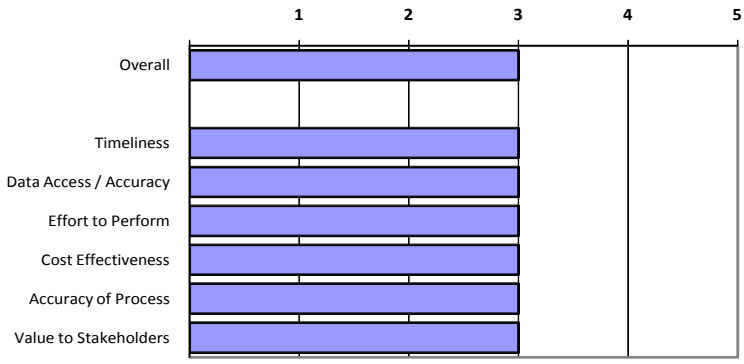
10.2.4 Systems and Datasets

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes - RI Eligibility system used for determination and enrollment information.

10.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Prepare RIte Share Premium Payments process are rated at a Level 3 capability as this business process is completely automated. This business process requires little to no manual intervention.

Figure 43 Current Maturity Levels by Dimension: Prepare RIte Share Premium Payments



Examples of the qualities and characteristics that support these ratings include the following:

- The Rite Share premium payment process is fully automated
- Requires no manual intervention

Table 42 Assessed Maturity Level by MITA Quality: Prepare RIte Share Premium Payments

MITA BCM Qualities & Characteristics	Level
OVERALL	**3**
Timeliness	**3**
Process time can be immediate. Interagency collaboration, use of data sharing standards, and State/regional information exchange improves timeliness. Turnaround time can be immediate.	3
Data Access & Accuracy	**3**
The agency identifies members who meet criteria for buy-in to other insurance coverage through primarily manual processes including a cost/benefit analysis of the individual case.	N/A
Medicaid collaborates with other payers to use the national standards	3
Access to clinical information helps to identify members eligible for other insurance programs. (Level 4 only)	N/A
Effort to Perform	**3**

MITA BCM Qualities & Characteristics	Level
Verification is fully automated and immediate. Automated verification and application response are real time.	3
Cost Effectiveness	**3**
Further reduction of staff required to perform business process.	3
Accuracy of Process	**N/A**
The agency has the flexibility to easily change the criteria for identification of members eligible for other insurance buy-in.	3
Utility or Value to Stakeholders	**3**
Agencies benefit from sharing of the business service and information with other agencies.	3

10.3 Prepare Medicare Premium Payment

10.3.1 MITA Business Process

Tier 4: Prepare Medicare Premium Payment	
Item	**Details**
Description	State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance. The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading. NOTE: This process does not include sending the Medicare premium payments EDI transaction.

10.3.2 RI Business Process Overview

The Prepare Medicare Premium Payment Business Process is overseen and performed by the Department of Human Services' Budgets and Accounting Unit. The DHS Eligibility Reconciliation Unit performs the business process steps associated with reconciliation of the Medicare buy-in file.

The MMIS Fiscal Agent, HP, does not have a role in the Prepare Medicare Premium Payment business process.

10.3.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Post buy-in changes to the MMIS member information (Changes are posted in InRhodes and the MMIS is notified during nightly cycle)
- Produce buy-in reports reflecting potential Medicare eligibles including any additions or deletions to existing eligibility registry as well as other problems (Reports of potential Medicare eligibles are not produced.)
- Verify whether co-insurance and deductible payments are required in addition to the premiums (DHS does not do this as part of the Medicare premium payment process.)
- Format the payment data set (DHS approves the invoice from CMS for payment)

10.3.4 Systems and Datasets

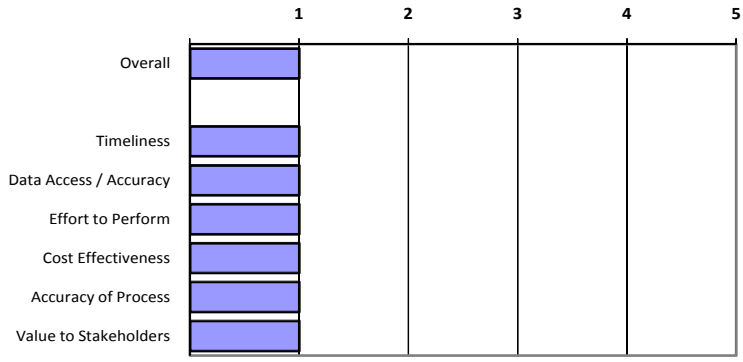
The major systems and datasets that store, transact or exchange data in support of the Medicare Premium Payment process include:

- InRhodes - RI Eligibility system used for determination and enrollment information.
- RI-FANS – State's accounting system

10.3.5 Maturity Characteristics

As shown in the graphic and table that follows, the overall rating for the Prepare Medicare Premium Payment Business Process is rated at a Level 1 capability.

Figure 44 Current Maturity Levels by Dimension: Prepare Medicare Premium Payment



Examples of the qualities and characteristics that support these ratings include the following:

- BENDEX file from CMS is received automatically into InRhodes
- DHS staff perform reconciliation of Medicaid eligibles to Medicare eligibles manually
- CMS invoice is approved and payment request is a manual process.

Table 43 Assessed Maturity Level by MITA Quality: Prepare Medicare Premium Payment

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	**N/A**
The agency identifies members who meet criteria for buy-in to Medicare Part B. The agency prepares the Medicare Part B premium buy-in report (RI does not produce this report).	N/A
The agency exchanges information with the SSA using electronic communication standards specified by SSA. At Level 1, tape exchange is the primary medium (RI does not exchange SSA data via tape).	N/A

MITA BCM Qualities & Characteristics	Level
CMS has not adopted the HIPAA standard for premium payment for this transaction so there is no national improvement available for this part of the process.	N/A
Effort to Perform	**1**
Updates are completed (keyed) manually.	1
Cost Effectiveness	**1**
Large number of staff required to perform business process. (Relative to RI)	1
Accuracy of Process	**1**
Inconsistent decision making/validation.	1
Utility or Value to Stakeholders	**1**
Focus is on conducting business functions as efficiently as possible.	1

10.4 Prepare RIte Care Member Premium Invoice

10.4.1 MITA Business Process

Tier 3: Prepare Member Premium Invoice	
Item	**Details**
Description	Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The Prepare Member Premium Invoice business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Maintain Member Information process for updating. NOTE: This process does not include sending the member premium invoice EDI transaction.

10.4.2 RI Business Process Overview

RIte Care is Rhode Island's Medicaid managed care program. It is overseen by the Department of Human Services' Center for Child and Family Health. HP, the Fiscal Agent is responsible for generating a file from the Recipient Subsystem of those individuals with a RIte Care program indicator. HP then mails members their RIte Care premium invoice monthly.

10.4.3 Business Process Variations

The Prepare RIte Care Member Premium Invoice business process does not significantly diverge from the MITA business process definition.

10.4.4 Systems and Datasets

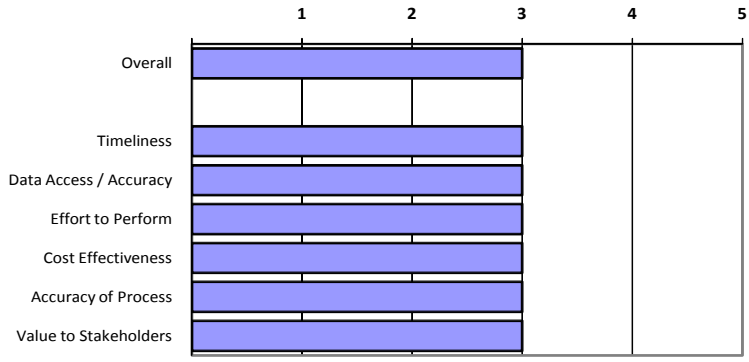
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- InRhodes - RI Eligibility system used for determination and enrollment information.

10.4.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Prepare RIte Care Premium Invoice process are rated at a Level 3 capability.

Figure 45 Current Maturity Levels by Dimension: Prepare RIte Care Member Premium Invoice



Examples supporting these process ratings include the following:

- Process is automated within the MMIS, however some manual effort is required

- Member RIte Care eligibility updates are automatically processed between InRhodes and the MMIS Recipient Subsystem
- Automation improves accuracy of responses

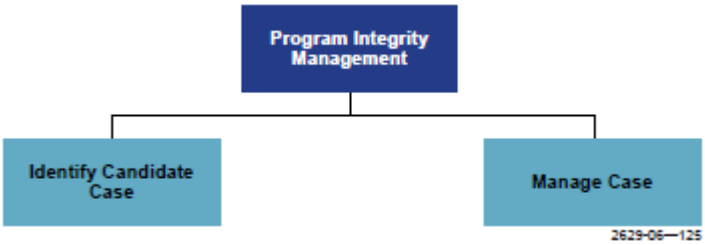
Table 44 Assessed Maturity Level by MITA Quality: Prepare RIte Care Member Premium Invoice

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Process time is faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement.	2
Payments can be accepted at all Agency sites. Payment can be in the form of cash, check, or credit or debt card.	3
Data Access & Accuracy	**3**
Information from all program eligibility systems is used to establish the amount of the member liability in a centralized member accounting system associated with the Member Registry	3
Member liability amounts are updated by MMIS with online adjustment capability. Member cost sharing accounts are maintained and updated by claims or member direct premium or pay in payments activity.	3
Details of the transaction are posted to the member accounting modules on the MMIS and then sent to the Agency financial systems.	3
Effort to Perform	**3**
The agency has the flexibility to easily change the criteria for rate cells.	3
Total payments are automatically compared to the member's benefit package requirement for out of pocket expenses.	3
Cost Effectiveness	**3**
Further reduction of staff required to perform business process.	3
Accuracy of Process	**3**
he process creates a debit when payments are made; overpayments are credited to the account and refunds made to the member by check, EBT.	3
Utility or Value to Stakeholders	**3**

MITA BCM Qualities & Characteristics	Level
Notices automatically are sent to the member from a central enterprise-wide member communications	3

11 PROGRAM INTEGRITY MANAGEMENT

There are two business processes defined within the MITA framework for Program Integrity Management.



The RI Medicaid program performs all of the defined business processes:

- Identify Candidate Case
- Manage Case

11.1 Identify RI Medicaid Candidate Case

11.1.1 MITA Business Process Model

Tier 2: Identify Candidate Case	
Item	**Details**
Description	The Identify Candidate Case business process uses State specific criteria and rules to identify target populations (e.g., providers, contractors, or beneficiaries), establishes patterns or parameters of acceptable/unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Candidate cases may be identified for: ■ Provider utilization review ■ Contractor ■ Beneficiary utilization review ■ Potential fraud ■ Drug utilization review ■ Quality review Each type of case is driven by different State criteria and rules, different relationships, and different data.

11.1.2 RI Business Process Overview

The Identify RI Medicaid Candidate Case business process is performed by the MMIS Fiscal Agent, HP, and overseen by DHS Program Integrity Section. Program Integrity coordinates with other DHS Divisions and government agencies for referrals, data and investigative support. The Program Integrity Section coordinates fraud and abuse case with Medicaid Fraud Control Unit (MFCU).

11.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Notify affected parties: correspond with providers, beneficiaries, agents, guardians, attorneys, et al to notify them regarding the investigation, their

rights, and the right of the Medicaid agency to request documentation (Program Integrity may not contact parties to the investigation until DHS is ready to take action – if no action is taken, the parties may not be notified)

11.1.4 Systems and Datasets

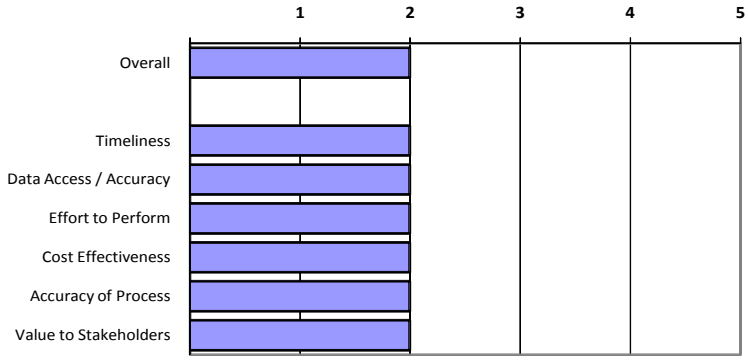
The following are examples of the major systems that store, transact or exchange data in support of this process:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DSS Profiler System – used to identify potentially fraudulent or abusive practices by both those who provide and receive healthcare services. It can be used to analyze fee-for-service and managed care.

11.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Identify RI Medicaid Candidate Case overall business process are rated at a Level 2 capability.

Figure 46: Current Maturity Levels by Dimension: Identify RI Medicaid Candidate Case



Examples of the qualities and characteristics that support these ratings include the following:

- An Excel file is used for case tracking and managing information related to provider and beneficiary investigations
- Although basic case data are collected and reported in a standardized manner, investigative methods and standards may vary by case type and eligibility category
- Outcomes may take several months
- Cases are identified through a variety of methods, including a variety of rich data sets
- General access to State website for reporting potential fraud and abuse
- Data collected is manually from various sources

Table 45: Assessed Maturity Level by MITA Quality: Identify RI Medicaid Candidate Case

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Timeliness exceeds legal requirements.	2
Data Access & Accuracy	**2**
Introduction of automated rules.	2
Data is accessed / transferred / received via Web portals, email. Automation increases accuracy of data.	2
Records for different programs continue to be stored separately but can be accessed and aggregated as needed.	2
Responses to requests for information are automated.	2
Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.	N/A

MITA BCM Qualities & Characteristics	Level
Rules/criteria and access points for similar business functions are the same across program areas.	2
Effort to Perform	**2**
Updates are automatically processed.	2
Cost Effectiveness	**2**
Less staff required to perform business process. Automation leads to few staff. Responses per day increase.	2
Accuracy of Process	**2**
More consistency in decision making/rules/validation	2
Utility or Value to Stakeholders	**2**
Automation and coordination processes enable staff to focus more on member and provider management.	2

11.2 Manage RI Medicaid Case

11.2.1 MITA Business Process

Tier 2: Manage Case	
Item	**Details**
Description	The Manage Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, or beneficiary from the Medicaid program; or the case may be terminated or suspended. Individual State policy determines what evidence is needed to support different types of cases: ■ Provider utilization review ■ Provider compliance review ■ Contractor utilization review ■ Contractor compliance review ■ Beneficiary utilization review ■ Investigation of potential fraud ■ Drug utilization review ■ Quality review ■ Performance review Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.

11.2.2 RI Business Process Overview

The Manage RI Medicaid Case business process is overseen by DHS Program Integrity Section. Program Integrity coordinates with other DHS Divisions and government agencies for referrals, data and investigative support. Program Integrity coordinates fraud and abuse case with Medicaid Fraud Control Unit (MFCU).

11.2.3 Business Process Variations

The following is an example of elements in this business process that diverge from the MITA definition:

- Notify affected parties: correspond with providers, beneficiaries, agents, guardians, attorneys, et al to notify them regarding the investigation, their rights, and the right of the Medicaid agency to request documentation (Program Integrity may not notify parties of the investigation until DHS is ready to take action – if no action is taken, the parties may not be notified)

11.2.4 Systems and Datasets

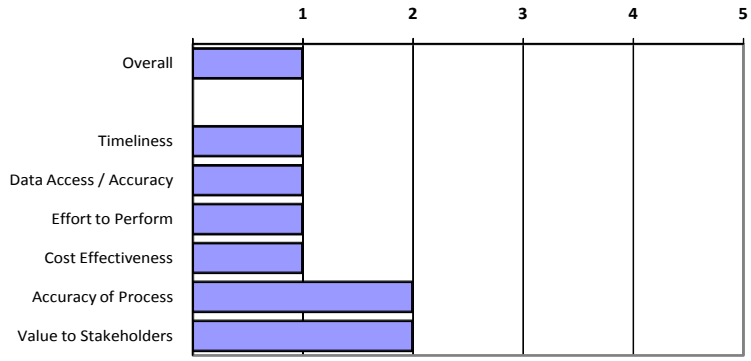
The following are examples of the major systems that store, transact or exchange data in support of this process:

- RI MMIS - used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DSS Profiler System – is used to identify potentially fraudulent or abusive practices by both those who provide and receive healthcare services. It can be used to analyze fee-for-service and managed care.
- CHOICES Data Warehouse – used to gather payment, provider, eligibility and case management data from the RI MMIS, InRhodes, DEA SAMS, Personal Choices, DEA RIPAE, CSM, BHDDH DD, and US Census data into an integrated, knowledge-based system used by staff from DHS and other state organizations.

11.2.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage RI Medicaid Case business process is rated at a Level 1 capability. While much of the investigative process involves manual effort, data access and accuracy are enhanced with the centralized web-based case tracking tool.

Figure 47: Current Maturity Levels by Dimension: Manage RI Medicaid Case



Examples of the qualities and characteristics that support these rating include the following:

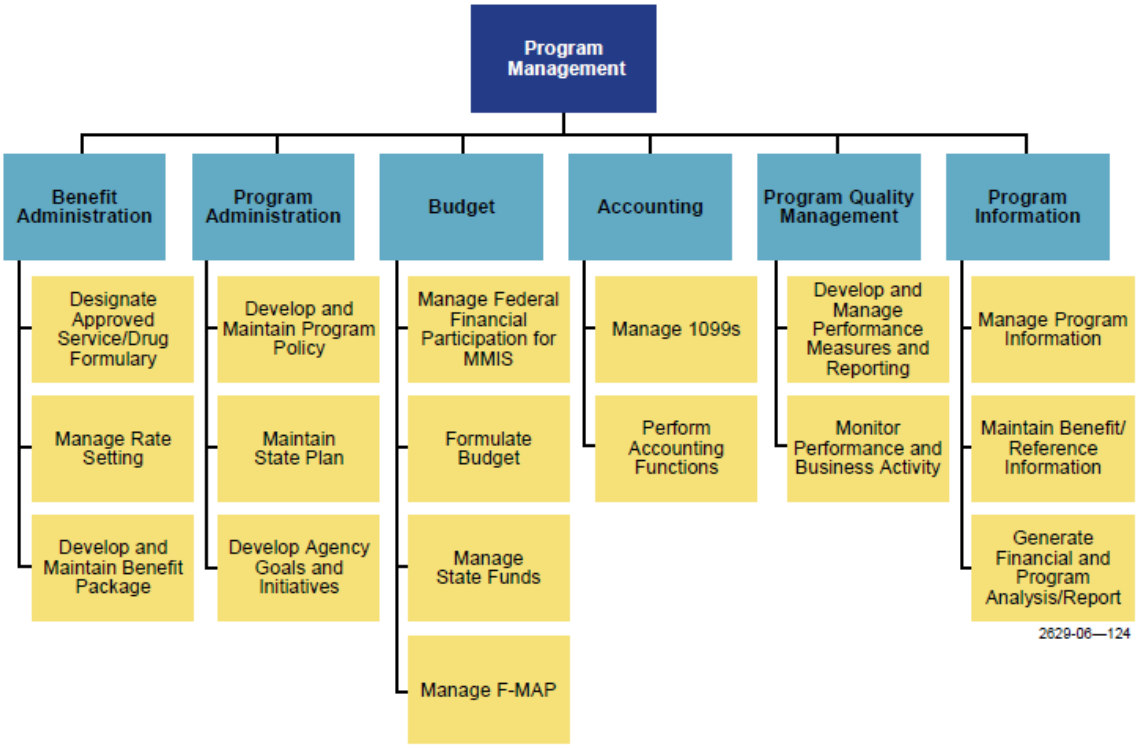
- An Excel file is used for case tracking and managing information related to provider and beneficiary investigations
- Although basic case data are collected and reported in a standardized manner, investigative methods and standards may vary by case type and eligibility category
- Outcomes may take several months
- Cases are identified through a variety of methods, including a variety of rich data sets
- General access to State website for reporting potential fraud and abuse
- Data collected is manually from various sources

Table 46: Assessed Maturity Level by MITA Quality: Manage RI Medicaid Case

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions may take several days. Timelapse of process is within agency, state and federal guidelines.	1
Data Access & Accuracy	**1**
Introduction of automated rules.	2
Data is accessed / transferred / received on paper and some electronic; phones and faxes are used to communicate information. Some proprietary EDI.	1
Records for different programs continue to be stored separately but can be accessed and aggregated as needed.	2
Responses to requests for information are automated.	2
Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.	N/A
Rules/criteria and access points for similar business functions are the same across program areas.	N/A
Effort to Perform	**1**
Updates are completed (keyed) manually.	1
Cost Effectiveness	**1**
Large number of staff required to perform business process. (Relative to RI)	1
Accuracy of Process	**2**
More consistency in decision making/rules/validation	2
Utility or Value to Stakeholders	**2**
Automation and coordination processes enable staff to focus more on member and provider management.	2

12 PROGRAM MANAGEMENT

There are seventeen business processes defined within the MITA framework for Program Management.



The RI Medicaid program performs all of the defined business processes:

- Designate Approved Service Drug Formulary
- Develop Agency Goals and Initiatives
- Develop and Maintain Benefit Package
- Develop and Maintain Program Policy
- Develop and Manage Performance Measures/Reporting
- Formulate Budget

- Generate Financial and Program Analysis Report
- Maintain Benefits-Reference Information
- Maintain State Plan
- Manage 1099s
- Manage FFP for MMIS
- Manage FMAP
- Manage Program Information
- Manage Rate Setting
- Manage Rate Setting
- Manage State Funds
- Perform Accounting Functions

12.1 Designate Approved Drug Formulary

12.1.1 MITA Business Process

Tier 3: Designate Approved Service/Drug Formulary	
Item	**Details**
Description	The Designate Approved Services and Drug Formulary business process begins with a review of new and/or modified service codes (such as HCPCS and ICD-9) or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package. Service, supply, and drug codes are reviewed by an internal or external team(s) of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or State plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes. NOTE: This does not include implementation of Approved Services and Drug Formulary.

12.1.2 RI Business Process Overview

The Designate Approved Drug Formulary process is overseen by the Pharmacy Chief at the DHS. Magellan Health Services, a third party contractor, reviews new industry standard drug codes quarterly and makes a recommendation on which codes it recommends RI to include. The DHS has a review panel of physicians and pharmacists that approve/deny recommendations from Magellan.

The Designate Approved Drug Formulary process is assessed separately from the Designate Approved Service which also maps to the MITA Business process, Designate Approved Service / Drug Formulary.

12.1.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Review and identify changes to State Plan (in general, drug code updates do not require State Plan amendments unless new benefits are introduced).
- Produce notifications for vendors, providers, and impacted members (notifications are not normally done).

12.1.4 Systems and Datasets

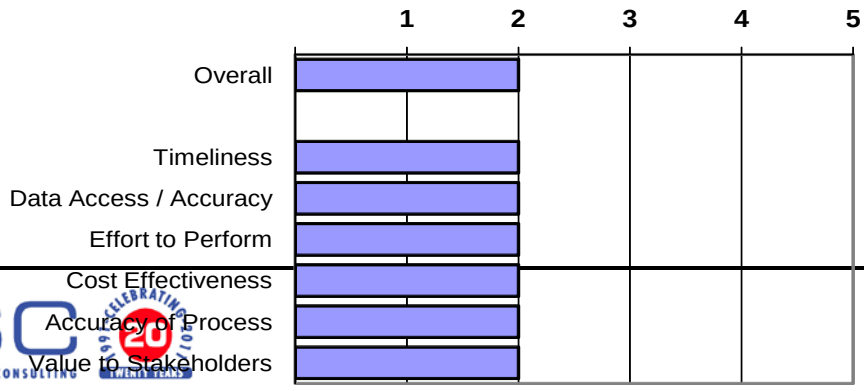
The major systems and datasets that store, transact or exchange data in support of the Designate Approved Drug Formulary process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

12.1.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Designate Approved Drug Formulary process are rated at a Level 2.

Figure 48 Current Maturity Levels by Dimension: Designate Approved Drug Formulary



Examples supporting these Designate Approved Drug Formulary process ratings include the following:

- Standard, timely review process in place
- Drug code files are received electronically
- Drug formulary maintained in MMIS

Table 47 Assessed Maturity Level by MITA Quality: Designate Approved Drug Formulary

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Communications to customers are more consistent, timely and appropriate then level 1.	2
Data Access & Accuracy	**2**
At this level, the Designate Approved Services/Drug Formulary process begins to be coordinated across siloed systems and centralized by the enterprise. Review processes are centralized and standardized processes are emerging across systems, types of service and benefit packages.	2
Effort to Perform	**2**
Agencies begin to centralize provider notification and client communication functions requiring fewer staff and capitalizing on efficiencies.	2
Cost Effectiveness	**2**
Agencies begin to centralize provider notification and client communication functions requiring fewer staff and capitalizing on efficiencies.	2
Accuracy of Process	**2**
Decisions continue to be primarily based on fiscal impacts and regulatory requirements, but increased use of EDI increases accuracy of and access to clinical data to allow for limited analysis of health care outcomes as a determining factor.	2
Utility or Value to Stakeholders	**2**

MITA BCM Qualities & Characteristics	Level
Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers.	2
Customers are able to access the information required regardless of their entry point into the enterprise (level 3 only).	N/A
The Agency actively supports and enables its customers to access information electronically (level 3 only).	N/A

12.2 Designate Approved Medicaid Service

12.2.1 MITA Business Process

Tier 3: Designate Approved Service/Drug Formulary	
Item	**Details**
Description	The Designate Approved Services and Drug Formulary business process begins with a review of new and/or modified service codes (such as HCPCS and ICD-9) or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package. Service, supply, and drug codes are reviewed by an internal or external team(s) of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or State plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes. NOTE: This does not include implementation of Approved Services and Drug Formulary.

12.2.2 RI Business Process Overview

The Designate Approved Medicaid Service process is overseen by the MMIS fiscal agent, HP, in conjunction with the DHS. HP receives an annual, electronic download from CMS of new codes and code changes. HP makes recommendations to the DHS of new codes and awaits approval before implementation.

The Designate Approved Medicaid Service process is assessed separately from the Designate Approved Drug Formulary which also maps to the MITA Business process, Designate Approved Service / Drug Formulary.

12.2.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Review and identify changes to State Plan (in general, service code updates do not require State Plan amendments unless new benefits are introduced).
- Produce notifications for vendors, providers, and impacted members (notifications are not normally done).

12.2.4 Systems and Datasets

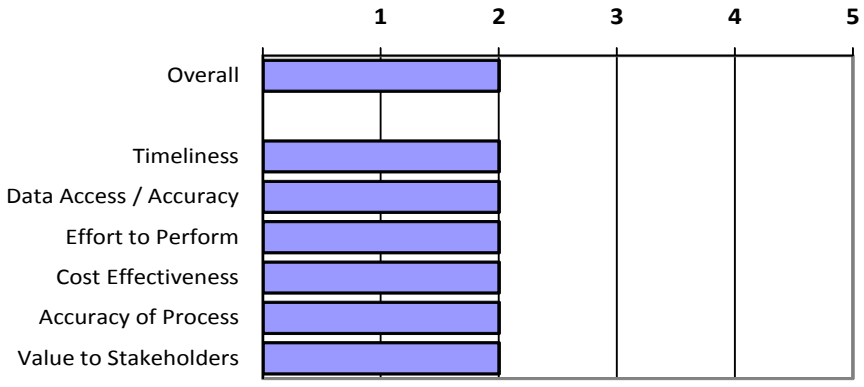
The major systems and datasets that store, transact or exchange data in support of the Designate Approved Medicaid Service process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

12.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Designate Approved Medicaid Service process are rated at a Level 2.

Figure 49 Current Maturity Levels by Dimension: Designate Approved Medicaid Service



Examples supporting these Designate Approved Medicaid Service process ratings include the following:

- Standard, timely review process in place
- CMS code files are received electronically
- Service codes maintained in the MMIS

Table 48 Assessed Maturity Level by MITA Quality: Designate Approved Medicaid Service

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Communications to customers are more consistent, timely and appropriate then level 1.	2
Data Access & Accuracy	**2**
At this level, the Designate Approved Services/Drug Formulary process begins to be coordinated across siloed systems and centralized by the enterprise. Review processes are centralized and standardized processes are emerging across systems, types of service and benefit packages.	2
Effort to Perform	**2**
Agencies begin to centralize provider notification and client communication functions requiring fewer staff and capitalizing on efficiencies.	2
Cost Effectiveness	**2**
Agencies begin to centralize provider notification and client communication functions requiring fewer staff and capitalizing on efficiencies.	2
Accuracy of Process	**2**
Decisions continue to be primarily based on fiscal impacts and regulatory requirements, but increased use of EDI increases accuracy of and access to clinical data to allow for limited analysis of health care outcomes as a determining factor.	2
Utility or Value to Stakeholders	**2**
Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers.	2

MITA BCM Qualities & Characteristics	Level
Customers are able to access the information required regardless of their entry point into the enterprise (level 3 only).	N/A
The Agency actively supports and enables its customers to access information electronically (level 3 only).	N/A

12.3 Develop and Maintain Benefit Package

12.3.1 MITA Business Process

Tier 3: Develop & Maintain Benefit Package	
Item	**Details**
Description	The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations, changes resulting from court decisions, or medical procedures or processes. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including, but not limited to: ■ Determination of scope of coverage ■ Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc. ■ Identification of impacted members and trading partners such as Medicaid managed care plans or clearinghouses.

12.3.2 RI Business Process Overview

The Develop and Maintain Benefit Package process is performed primarily by the DHS, Center for Child and Family Health with other program input as necessary. This is an ongoing, dynamic process based upon monthly quality of care reviews done internally. Analytical analyses are reviewed and discussed at monthly meetings to determine if any changes to the package of services included in each program need to be updated or changed. One of the more common changes is to bring in a new population into Managed Care.

12.3.3 Business Process Variations

The Develop and Maintain Benefit Package business process does not significantly diverge from the MITA business process definition.

12.3.4 Systems and Datasets

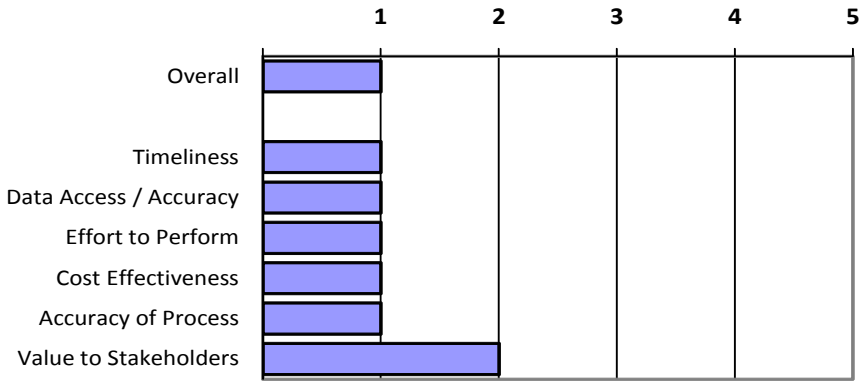
The major systems and datasets that store, transact or exchange data in support of the Develop and Maintain Benefit Package process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- SAS – statistical application used for rate determination and data analyses within program management.

12.3.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Develop and Maintain Benefit Package process are at a Level 1 rating.

Figure 50 Current Maturity Levels by Dimension: Develop and Maintain Benefit Package



Examples supporting these Develop and Maintain Benefit Package process ratings include the following:

- Process is "data driven"
- SAS statistical package is used for analysis of data
- DHS has to notify HP by the FACN process to update benefit package information

Table 49 Assessed Maturity Level by MITA Quality: Develop and Maintain Benefit Package

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The benefit package changes take a significant amount of time to complete, depending on the complexity and cost of coverage affected.	**1**
Data Access & Accuracy	**1**
The manual nature of this process introduces the potential for inaccuracies.	**1**
The benefit package details are not published or widely distributed.	**1**
Effort to Perform	**1**
Changes to the benefit plan are primarily manual creating inefficiency.	**1**
Cost Effectiveness	**1**
Benefit package maintenance is duplicated among multiple agencies including the Medicaid agency. Lack of coordination reduces effectiveness.	**1**
Accuracy of Process	**1**
Benefit packages are inflexible and lock members into a single package.	**1**
Utility or Value to Stakeholders	**2**
Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	**2**

12.4 Manage Managed Care Rate Setting

12.4.1 MITA Business Process

Tier 3: Manage Rate Setting	
Item	**Details**
Description	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.

12.4.2 RI Business Process Overview

The Manage Managed Care Rate Setting process is performed by the DHS, Child and Family Services. The Rate Setting process is "data driven" based upon encounters submitted by the Managed Care plans, taking into consideration offsets like the cost of re-insurance to the plans. Any new services being added to the scope of covered services is also accounted for in rate determination.

The Rate Setting process is done annually for each line of business (RIte Care, CSHCN, Rhody Health Partners). Data from MMIS encounter subsystem is loaded into SAS to calculate proposed rates. Data is sent to outside actuary to certify as "actuarially sound" and certify CMS guidelines were utilized. Rates are communicated to the MMIS FI agent, HP, to load into the MMIS for payment.

This process has its own distinct set of functions from those separately assessed for Manage RI Medicaid Rate Setting, which also maps to the MITA Manage Rate Setting business process.

12.4.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Receive notification of rate (DHS goes through an annual process to determine rates for the Managed Care Plans).

- Validate rate or establish rate (DHS utilizes an actuary to validate rates and certify them as "actuarially sound" according to CMS guidelines).
- Create rate update (DHS sends the new rate information to HP through the FACN process).

12.4.4 Systems and Datasets

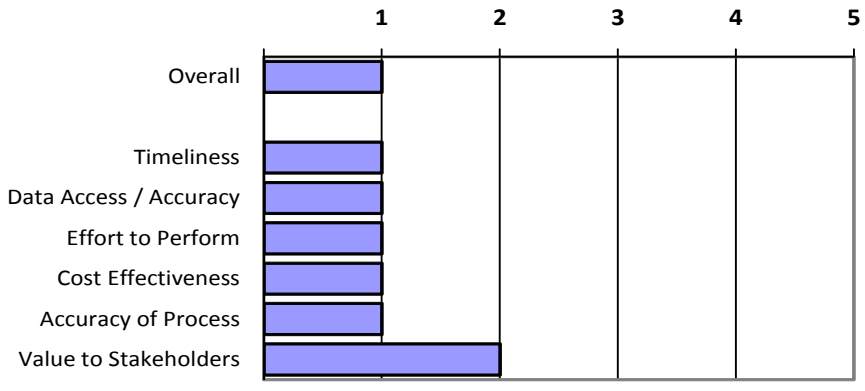
The major systems and datasets that store, transact or exchange data in support of the Manage Managed Care Rate Setting process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- SAS – statistical application used for rate determination and data analyses within program management.

12.4.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage Managed Care Rate Setting process are at a Level 1.

Figure 51 Current Maturity Levels by Dimension: Manage Managed Care Rate Setting



Examples supporting these Manage Managed Care Rate Setting process ratings include the following:

- Data from MMIS encounter subsystem is used to calculate proposed rates
- SAS statistical package is used for analysis of data
- Standard rules are used by actuary according to CMS guidelines

Table 50 Assessed Maturity Level by MITA Quality: Manage Managed Care Rate Setting

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The process meets State target dates for periodic updates to reimbursement rates.	**1**
Data Access & Accuracy	**1**
Manual operation results in subjective selection of data to be used.	**1**
Access to data is controlled manually. Data is stored in multiple locations and different standards may apply.	**1**
Effort to Perform	**1**
Manual processes create inefficiencies.	**1**
Cost Effectiveness	**1**
Manual processes and lack of standards negatively impact cost-effectiveness.	**1**
Accuracy of Process	**1**
Manual inputs into system and payment rates are manually validated resulting in potential inconsistency or invalid rates.	**1**
Utility or Value to Stakeholders	**2**
States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	**2**

12.5 Manage RI Medicaid Rate Setting

12.5.1 MITA Business Process

Tier 3: Manage Rate Setting	
Item	**Details**
Description	The Established Rate Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.

12.5.2 RI Business Process Overview

The Manage RI Medicaid Rate Setting process is performed by the DHS, Rate Setting Unit within Operations and Payments. The Manage RI Medicaid Rate Setting process covers four Provider Types:

- Pediatric Health Centers – submit paper cost reports annually. May request rate change during year. DHS evaluates request for validity and determines new rate when appropriate.
- Federally Qualified Health Centers – submit cost reports (CMS 222) based on fiscal year end. Facilities are held to state standards.
- Hospitals – are strictly paid on a DRG basis.
- Nursing Homes – submit cost reports on a standard state form at calendar year end. May request rate change during year. DHS evaluates request for validity and determines new rate when appropriate.

Rates for Medicaid services administered by other departments (BHDDH, DEA and DCYF) are managed within the perspective department.

This process has its own distinct set of functions from those separately assessed for Manage Managed Care Rate Setting, which also maps to the MITA Manage Rate Setting business process.

12.5.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Receive notification of rate (DHS determines rates based upon receipt of cost reports from the providers/facilities annually. Re-evaluation of rates mid-year are initiated by a request from the provider/facility).
- Create rate update (DHS sends the new rate information to HP through the FACN process).

12.5.4 Systems and Datasets

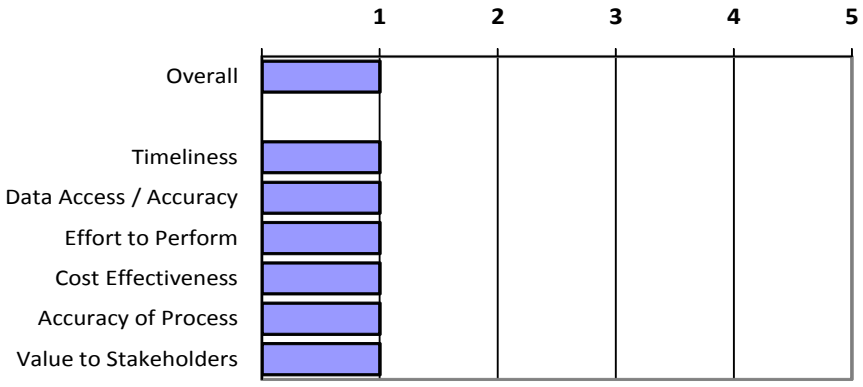
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Rate Setting process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization..
- Rate Setting Excel Workbook- Used by the DHS Rate Setting Unit to determine rates based up on provider submitted cost reports.

12.5.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Rate Setting process are rated at a Level.

Figure 52 Current Maturity Levels by Dimension: Manage RI Medicaid Rate Setting



Examples supporting these Manage RI Medicaid Rate Setting process ratings include the following:

- Process is manual
- Cost reports are submitted on paper
- Cost reports are not standardized

Table 51 Assessed Maturity Level by MITA Quality: Manage RI Medicaid Rate Setting

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The process meets State target dates for periodic updates to reimbursement rates.	**1**
Data Access & Accuracy	**1**
Manual operation results in subjective selection of data to be used.	**1**
Access to data is controlled manually. Data is stored in multiple locations and different standards may apply.	**1**
Effort to Perform	**1**
Manual processes create inefficiencies.	**1**

MITA BCM Qualities & Characteristics	Level
Cost Effectiveness	**1**
Manual processes and lack of standards negatively impact cost-effectiveness.	**1**
Accuracy of Process	**1**
Manual inputs into system and payment rates are manually validated resulting in potential inconsistency or invalid rates.	**1**
Utility or Value to Stakeholders	**1**
Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	**1**

12.6 Develop Agency Goals and Objectives

12.6.1 MITA Business Process

Tier 3: Develop Agency Goals and Objectives	
Item	**Details**
Description	The Develop Agency Goals and Objectives business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Changes to goals and objectives could be warranted for example, under a new administration; or in response to changes in demographics, public opinion or medical industry trends; or in response to regional or national disasters.

12.6.2 RI Business Process Overview

The Develop Agency Goals and Objectives process is performed by the DHS Medicaid Director and senior management staff. Staff are encouraged to suggest initiatives to pursue that will promote the health and well-being of the member population. Weekly meetings are held with senior management to discuss opportunities, ideas and other funding sources available. The process is less formal than a typical strategic planning process.

12.6.3 Business Process Variations

The Develop Agency Goals and Objectives business process does not significantly diverge from the MITA business process definition.

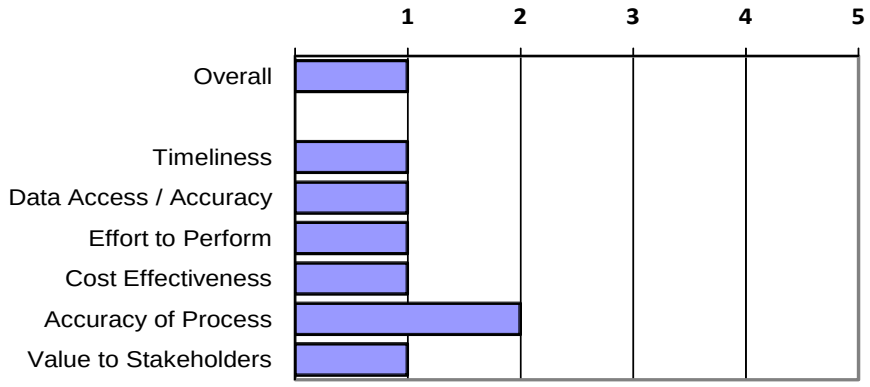
12.6.4 Systems and Datasets

Maintenance of the Agency Goals and Objectives is a manual process not supported by any of the major RI systems.

12.6.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Develop Agency Goals and Objectives process are rated at a Level 1 with the exception of Accuracy of Process at a Level 2.

Figure 53 Current Maturity Levels by Dimension: Develop Agency Goals and Objectives



Examples supporting these Develop Agency Goals and Objectives process ratings include the following:

- Updates to Agency Goals and Objectives are done manually
- A formal process is not defined or documented

Table 52 Assessed Maturity Level by MITA Quality: Develop Agency Goals and Objectives

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The goals and objectives are developed in an ad hoc manner. This may be triggered by a change in Administration or in receipt of revenue.	1
Data Access & Accuracy	**1**
The agency is a silo and does not gather information from other agencies. Goals and objectives are vague and incomplete. Information gathered can be inaccurate, incomplete, or does not apply.	1

MITA BCM Qualities & Characteristics	Level
The goals and objectives are vague and incomplete. The information needed is not readily available, located in many places, out-of-date, and difficult to verify.	1
Effort to Perform	**1**
Measurement of efficiency is difficult due to the general and vague nature of the goals and objectives and the infrequent nature of the process.	1
Cost Effectiveness	**1**
Cost measurement is difficult due to the general and vague nature of the goals and objectives and the ad hoc nature of the process.	1
Accuracy of Process	**2**
Standardized methodologies produce goals and objectives that are easily traceable throughout the organization.	2
Utility or Value to Stakeholders	**1**
The general and vague nature of goals and objectives are not useful to stakeholders.	1

12.7 Develop and Maintain Program Policy

12.7.1 MITA Business Process

Tier 3: Develop and Maintain Program Policy	
Item	**Details**
Description	The Develop and Maintain Program Policy Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: federal or state statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; federal or state audits; enterprise decisions; and consumer pressure.

12.7.2 RI Business Process Overview

The Develop and Maintain Program Policy process is performed by the DHS Medicaid Director and senior management staff. Budget initiatives are proposed with approval of policy changes from CMS. Once the policy change becomes part of the budget, an implementation plan is put together to roll-out the changes.

12.7.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Formulate and publish policy (policy is not "published" until implemented).
- Develops implementation plan for policy (this is done earlier in the process, before the public hearings are done).

12.7.4 Systems and Datasets

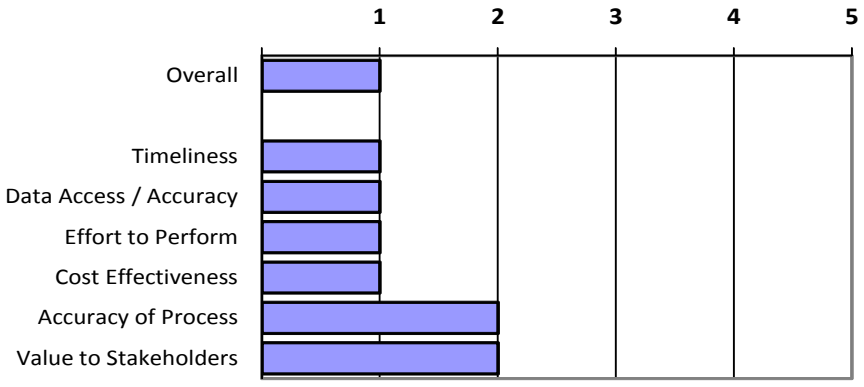
The major systems and datasets that store, transact or exchange data in support of the Develop and Maintain Program Policy process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- SAS – statistical application used for rate determination and data analyses within program management.
- RIte Share Database - Database used to analyze cost effectiveness of RIte Share program.

12.7.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Develop and Maintain Program Policy process are rated at a Level 1 with the exception of Accuracy of Process and Value to Stakeholders which are at a Level 2.

Figure 54 Current Maturity Levels by Dimension: Develop and Maintain Program Policy



Examples supporting these Develop and Maintain Program Policy process ratings include the following:

- Process is “data driven”
- SAS statistical package is used for analysis of data

- Updates to policy information is done manually

Table 53 Assessed Maturity Level by MITA Quality: Develop and Maintain Program Policy

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The program policy is not routinely reviewed unless requested by controlling entities. This manual process requires much time and effort to develop and/or modify the program policy.	**1**
Data Access & Accuracy	**1**
The information is manually gathered for the development and maintenance of the program policy making it prone to inaccuracies.	**1**
The program policy information needed is not readily available, located in many places, can be out-of-date, and difficult to verify.	**1**
Effort to Perform	**1**
The process requires significant effort and results are not timely.	**1**
Cost Effectiveness	**1**
The fully manual process requires significant human and system resources.	**1**
Accuracy of Process	**2**
Standardized methodologies provide for the development and maintenance of program policy that is easily traceable throughout the organization.	**2**
Utility or Value to Stakeholders	**2**
Standardization has provided clearer and more useful information for stakeholders resulting in increased stakeholder satisfaction over Level 1.	**2**

12.8 Maintain State Plan

12.8.1 MITA Business Process

Tier 3: Maintain State Plan	
Item	**Details**
Description	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.

12.8.2 RI Business Process Overview

The Maintain State Plan process is performed by the DHS Medicaid Director and senior management staff. State Plan updates are completed on an as-needed basis, not currently scheduled. Amendments are negotiated with CMS for approval and communicated once made. CMS publishes State Plan information on their web site but seem to no longer be maintaining it.

12.8.3 Business Process Variations

The Maintain State Plan business process does not significantly diverge from the MITA business process definition.

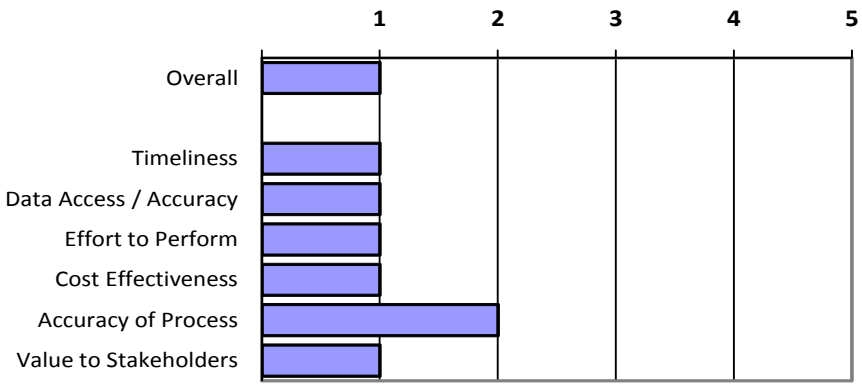
12.8.4 Systems and Datasets

Maintenance of the state plan is a manual process not supported by any of the major RI systems.

12.8.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Maintain State Plan process are rated at a Level 1 with the exception of Accuracy of Process at a Level 2.

Figure 55 Current Maturity Levels by Dimension: Maintain State Plan



Examples supporting these Maintain State Plan process ratings include the following:

- Updates to the State Plan are done manually
- Process is not on a scheduled basis, only as-needed.

Table 54 Assessed Maturity Level by MITA Quality: Maintain State Plan

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
All updates are manual and difficult to implement. Maintenance of State Plan is a year-round activity.	**1**
Data Access & Accuracy	**1**
The manual nature of this process increases the risk of unreliable and inaccurate information.	**1**
Information resides in multiple locations requiring time and effort to locate necessary information.	**1**
Effort to Perform	**1**
Process meets state objectives for maintaining State Plan.	**1**
Cost Effectiveness	**1**

MITA BCM Qualities & Characteristics	Level
This is a manual effort and requires time and effort to complete. Cost to benefit ratio is relatively high.	1
Accuracy of Process	**2**
Updates are better controlled, more timely, and accurate as compared to Level 1.	2
Utility or Value to Stakeholders	**1**
Stakeholder satisfaction is negatively impacted by manual processes, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	1

12.9 Manage State Funds

12.9.1 MITA Business process model

Tier 3: Maintain State Plan	
Item	**Details**
Description	The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.

12.9.2 RI Business Process Overview

The Manage State Funds process is performed by the DHS, Budget and Accounting. Budget categories are available within the State Accounting System, RI-FANS, but not at the level of detail available in the MMIS. Medicaid funds for Medical Assistance by budget category are reported by the MMIS Fiscal Agent, HP, on a monthly basis. Non-MMIS expenditures are included but are added manually.

12.9.3 Business Process Variations

The Manage State Funds business process does not significantly diverge from the MITA business process definition.

12.9.4 Systems and Datasets

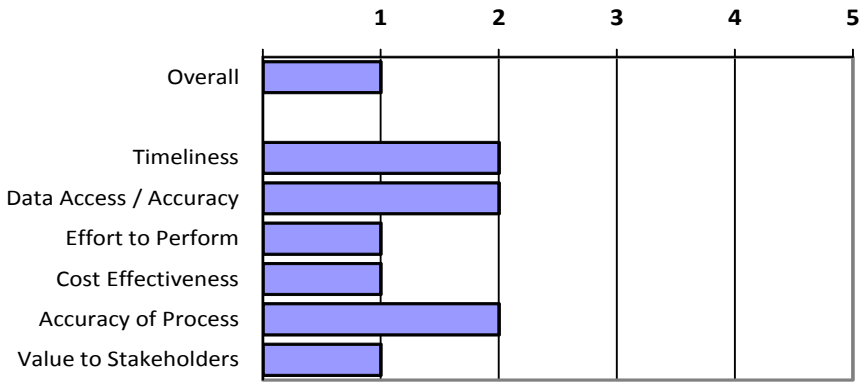
The major systems and datasets that store, transact or exchange data in support of the Manage State Funds process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- R-IFANS – State's accounting system.

12.9.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage State Funds process are rated at a Level 2 with the exception of Effort to Perform and Cost Effectiveness remain at Level 1.

Figure 56 Current Maturity Levels by Dimension: Manage State Funds



Examples supporting these Manage State Funds process ratings include the following:

- MMIS and non-MMIS expenditures are compiled using a manual process
- Mix of manual and automated steps
- MMIS and State Accounting System, RI-FANS, does not reconcile for monthly expenditures due mostly to timing of reporting

Table 55 Assessed Maturity Level by MITA Quality: Manage State Funds

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Less time is required than Level 1.	**2**
Data Access & Accuracy	**2**
Some automation improves accuracy and reduces errors.	**2**
Data is readily available to authorized users.	**2**
Effort to Perform	**1**
Minimally meets federal requirements for management of state funds. Manual processes create inefficiencies.	**1**
Cost Effectiveness	**1**
Meets Medicaid enterprise goals for completing allocation of state funds. Cost benefit ratio may not be able to be calculated.	**1**
Accuracy of Process	**2**
Automation reduces error rates and makes it easier to detect and correct errors.	**2**
Utility or Value to Stakeholders	**1**
Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	**1**

12.10 Formulate Budget

12.10.1 MITA Business Process

Tier 3: Formulate Budget	
Item	**Details**
Description	The Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.

12.10.2 RI Business Process Overview

The Formulate Budget process is performed by the DHS Medicaid Director and senior management staff and submitted to the EOHHS Budget Office for approval. Anyone on the senior management team can submit initiatives to be considered for the proposed Medicaid budget throughout the 5 year budget planning process. Case load estimates are compiled and reviewed during the budget conference with the Budget Office, House and Senate representatives and Fiscal Staff. Proposed budget can be approved or adjusted. The EOHHS Budget Office publishes the final, approved budget.

12.10.3 Business Process Variations

The Formulate Budget business process does not significantly diverge from the MITA business process definition.

12.10.4 Systems and Datasets

The major systems and datasets that store, transact or exchange data in support of the Formulate Budget process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as

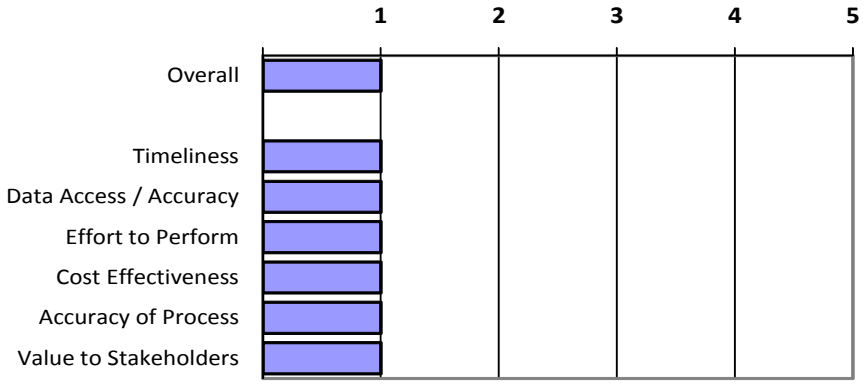
provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

- RI-FANS - State's accounting system.

12.10.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Formulate Budget process are rated at a Level 1.

Figure 57 Current Maturity Levels by Dimension: Formulate Budget



Examples supporting these Formulate Budget process ratings include the following:

- Updates to the Budget are done manually
- Mix of manual and automated steps
- No formal process exists to submit potential budget initiatives

Table 56 Assessed Maturity Level by MITA Quality: Formulate Budget

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
This business process is required to meet federal and State requirements to occur annually with quarterly updates. Preparation of quarterly updates can require up to three months.	**1**
Data Access & Accuracy	**1**
The information is based on financial cost data and cost estimates with standard inflation factor projection for future. Meets State requirements for accuracy.	**1**
The information is stored within Medicaid enterprise business units and is manually gathered and entered.	**1**
Effort to Perform	**1**
Process meets state objectives for budget formulation.	**1**
Cost Effectiveness	**1**
This is a manual effort and requires time and effort to complete. Cost to benefit ratio is relatively high.	**1**
Accuracy of Process	**1**
This business process is a mix of manual and automated activities and is dependent upon accuracy of data extracted from systems and accuracy of formulas within spreadsheet	**1**
Utility or Value to Stakeholders	**1**
Use of financial spreadsheet and automated processes for calculating and forecasting meets State goals for timeliness and accuracy of budget outcome.	**1**

12.11 Manage FFP for MMIS

12.11.1 MITA Business Process

Tier 3: Manage FFP for MMIS	
Item	**Details**
Description	The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS. The Manage Federal Financial Participation for MMIS business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.

12.11.2 RI Business Process Overview

The Manage FFP for MMIS process is performed by the DHS, Budget and Accounting. Multiple CMS required reports are produced for program management on a scheduled basis.

- CMS 64
- CMS 21
- CMS 21b
- CMS 37

12.11.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Analyze potential program additions, modifications or deletions for fiscal impact (changes to program policy are handled outside of this business process).

12.11.4 Systems and Datasets

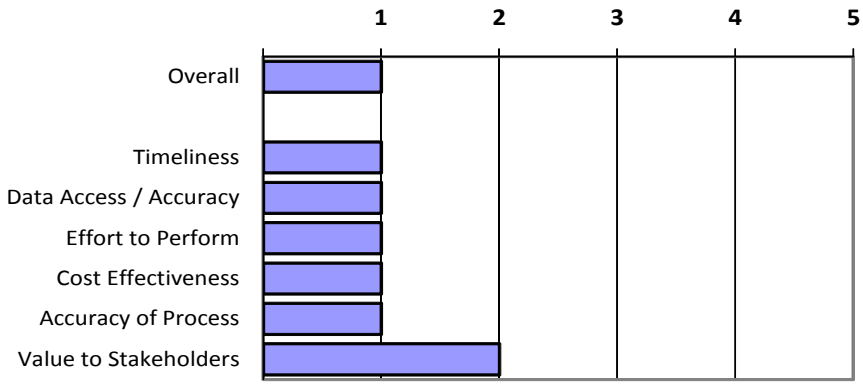
The major systems and datasets that store, transact or exchange data in support of the Manage FFP for MMIS process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization
- R-IFANS – State's accounting system.
- CMS 64 Quarterly Expense Report - Online tool provided by CMS for state to report annual cost.

12.11.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage FFP for MMIS process are rated at a Level 1.

Figure 58 Current Maturity Levels by Dimension: Manage FFP for MMIS



Exa

mples supporting these Manage FFP for MMIS process ratings include the following:

- Reports are compiled manually
- Expenditure projections are manually calculated
- Data and format are not standardized

Table 57 Assessed Maturity Level by MITA Quality: Manage FFP for MMIS

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Timeliness of responses to inquiries and data reporting is indeterminate. It takes several weeks to extract and manipulate data to produce standard reports requesting FFP for MMIS (e.g., CMS 64) or for APD.	**1**
Data Access & Accuracy	**1**
The manage FFP business process is a manual process that can lead to inaccuracies in data.	**1**
The process is a cyclical process that requires multiple efforts to access information from many sources.	**1**
Effort to Perform	**1**
The business process results meet State and federal requirements but require continuous manual efforts throughout the period of production of information for the report.	**1**
Cost Effectiveness	**1**
The manual nature of the process is time consuming and requires multiple iterations for documenting the FFP for MMIS.	**1**
Accuracy of Process	**1**
The manual nature of the process negatively impacts accuracy and may cause inaccuracies in the calculation of FFP for MMIS. State and federal audits discover errors in the process results.	**12**
Utility or Value to Stakeholders	**2**
Medicaid Enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities. Improvements are made strategically, increasing stakeholder satisfaction over Level 1.	**2**

12.12 Manage FMAP

12.12.1 MITA Business Process

Tier 3: Manage FMAP	
Item	**Details**
Description	The Manage FMAP (Federal Medical Assistance Percentages) business process periodically reviews and changes, as appropriate, the FMAP and enhanced FMAP rate used in the Manage FFP Business Process. (See 42 CFR 433.10) The US Department of Health and Humans Services (HHS) notifies the state of the "Federal Medical Assistance Percentages" (FMAP) and ``Enhanced Federal Medical Assistance Percentages'' (enhanced FMAP) that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid) and State Children's Health Insurance Program (SCHIP) expenditures for a specified federal fiscal year. The FMAP rates are reviewed and approved for application in enterprise accounting.

12.12.2 RI Business Process Overview

The Manage FMAP process is performed by the DHS, Budget and Accounting. Self-audits are done to look at how other departments are claiming Medicaid administrative expenditures.

12.12.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Propose change in approach to calculating FMAP, FFP (RI DHS accepts the FMAP levels set by the federal government and does not propose changes).
- Submit change for review and approval (N/A).
- Develop guidelines for change (N/A).
- Develop specific guidelines (N/A).

- Develop implementation plan (N/A).
- End: Publish new FFP rules (N/A).

12.12.4 Systems and Datasets

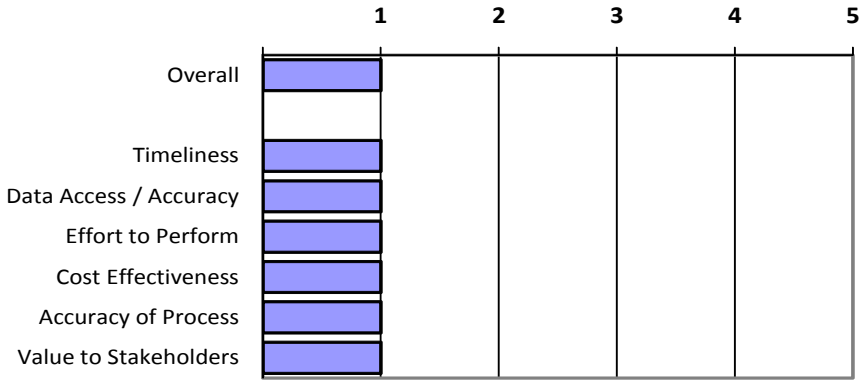
The major systems and datasets that store, transact or exchange data in support of the Manage FMAP process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- RI-FANS – State's accounting system.

12.12.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage FMAP process are rated at a Level 1.

Figure 59 Current Maturity Levels by Dimension: Manage FMAP



Examples supporting these Manage FMAP process ratings include the following:

- Reports are compiled manually
- There is no formal process defined
- Focus is on conducting business functions as efficiently as possible

Table 58 Assessed Maturity Level by MITA Quality: Manage FMAP

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
The process meets State and Federal guidelines for timeliness.	**1**
Data Access & Accuracy	**1**
Inconsistencies in data definitions lead to errors in correctly assigning FMAP rates; errors are detected and corrected.	**1**
Staff access multiple data sources that employ indeterminate standards. This adds difficulty to the process.	**1**
Effort to Perform	**1**
The process relies primarily on manual processes to collect data, analyze, and assign FMAP rates to services and recoveries, and monitor compliance.	**1**
Cost Effectiveness	**1**
The process meets State expectations.	**1**
Accuracy of Process	**1**
Manual processes can negatively impact accuracy. The process meets State and Federal expectations regarding results.	**1**
Utility or Value to Stakeholders	**1**
Stakeholder satisfaction is low, with few resources dedicated to improvement and few measurements in place, e.g. reliance on complaints, legal mandates for action regarding improving stakeholder satisfaction.	**1**

12.13 Manage 1099s

12.13.1 MITA Business Process

Tier 3: Manage 1099s	
Item	**Details**
Description	The Manage 1099s business process describes the process by which 1099s are handled, including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single Social Security Number or Federal Tax ID Number. The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Perform Accounting Functions process. The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.

12.13.2 RI Business Process Overview

The Manage 1099s process is overseen by the RI Department of Administration, Office of Accounts and Control. The DHS MMIS Fiscal Agent, HP, automatically creates an electronic file of all MMIS payments per provider for the calendar year. This file is used by the Office of Accounts and Control, along with non-MMIS, and non-Medicaid payment totals to produce a 1099 for each provider.

12.13.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Start: Receive claim/encounter payment and adjustment information..(HP generates and automatically sends an electronic file of all provider payments to the Office of Accounts and Control by provider tax ID).

12.13.4 Systems and Datasets

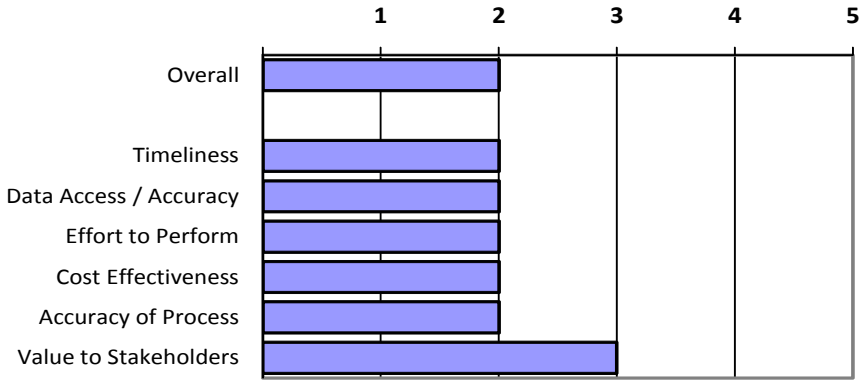
The major systems and datasets that store, transact or exchange data in support of the Manage 1099s process include:

- RI MMIS - RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- RI-FANS – State's accounting system

12.13.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Manage 1099s process are rated at a Level 3 with the Value to Stakeholders rated at a Level 3. The Manage 1099s business process is a highly automated process with little human intervention.

Figure 60 Current Maturity Levels by Dimension: Manage 1099s



Examples supporting these Manage 1099s process ratings include the following:

- Standard, timely review process in place

- Data exchange is electronic
- Centralized for all provider payments made by the EOHHS

Table 59 Assessed Maturity Level by MITA Quality: Manage 1099s

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Process time if faster than level 1 because of Web portal, EDI, or other automated form. Timeliness exceeds legal requirement. Decisions take less time than Level 1	2
Data Access & Accuracy	**2**
At this level, the Manage 1099s business process is increasing it's use of electronic interchange and automated processes.	2
Agencies are centralizing common processes to achieve economies of scale and increase coordination. Agency business relationships are increasingly hub and spoke vs point to point with each internal and external party. These changes improve customers' ability to reliably access the information and services they require.	2
Data is standardized for automated electronic interchanges (interfaces).	3
Effort to Perform	**2**
Agency business relationships are increasingly hub and spoke vs point to point with each internal and external party. The Agency likely has a central point for developing customer communications.	2
Cost Effectiveness	**2**
Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	2
Accuracy of Process	**2**
Centralization increases consistency of communications	2
Utility or Value to Stakeholders	**3**
The Agency actively supports and enables it's customers to access information electronically.	3

12.14 Perform Accounting Functions

12.14.1 MITA Business Process

Tier 3: Perform Accounting Functions	
Item	**Details**
Description	Currently States use a variety of solutions including outsourcing to another Department or use of a COTS package. Activities included in this process can be as follows: ■ Periodic reconciliations between MMIS and the system(s) that performs accounting functions ■ Assign account coding to transactions processed in MMIS ■ Process accounts payable invoices created in the MMIS. ■ Process accounts payable invoices created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables) ■ Load accounts payable data (warrant number, date, etc.) to MMIS ■ Manage canceled/voided/stale dated warrants ■ Perform payroll activities ■ Process accounts receivable (estate recovery, co-pay, drug rebate, recoupment, TPL recovery, and Member premiums) ■ Manage cash receipting process ■ Manage payment offset process to collect receivables ■ Develops and maintain cost allocation plans ■ Manages draws on letters of credit ■ Manages disbursement of federal administrative cost reimbursements to other entities ■ Respond to inquiries concerning accounting activities

12.14.2 RI Business Process Overview

The Perform Accounting Functions process is performed within the office of the CFO, EOHHS. The office monitors program expenditures and performs “draw-down” of federal matching funds as appropriate to state funds.

12.14.3 Business Process Variations

MITA business process definition was not complete within the framework. The version included in assessment report was created for RI based upon standard verbiage.

12.14.4 Systems and Datasets

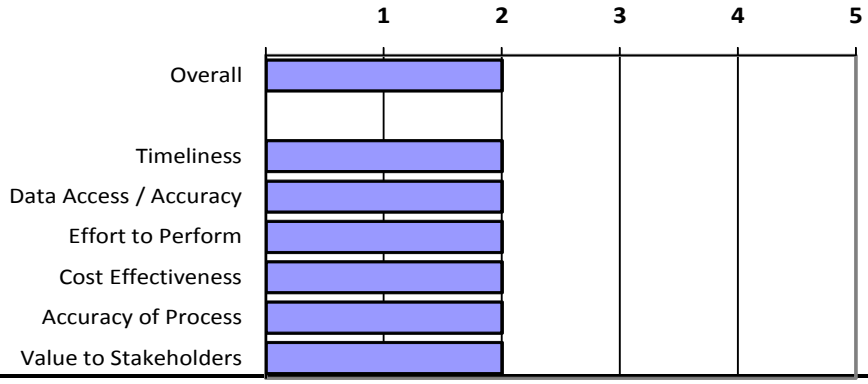
The major systems and datasets that store, transact or exchange data in support of the Perform Accounting Functions process include:

- RI-FANS – State's accounting system
- RICHIST - The Rhode Island Children's Information System (RICHIST) used by DCYF to administer Foster Care, Adoption, Juvenile Justice, Child Protective Services, Independent Living, Interstate Compact, Family Preservation and Support, Child and Family Services, Provider Services. RICHIST interfaces with the State Accounting System, InRHODES and the MMIS.

12.14.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Perform Accounting Functions process are rated at a Level 2.

Figure 61 Current Maturity Levels by Dimension: Perform Accounting Functions



Examples supporting these Perform Accounting Functions process ratings include the following:

- Process is centralized across departments within EOHHS to request federal matching funds.
- Increased use of electronic data exchange
- Business process is timely

Table 60 Assessed Maturity Level by MITA Quality: Perform Accounting Functions

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Communications to customers are more consistent, timely and appropriate then level 1	**2**
Data Access & Accuracy	**2**
At this level, a business process is increasing its use of electronic interchange and automated processes, e.g., OCR for paper transactions and AVR to automate phone lines.	**2**
Agencies are centralizing common processes to achieve economies of scale, increase coordination, improve rule application consistency, and standardizing data to increase its usefulness for performance monitoring, management reporting, fraud detection, and reporting and analysis.	**2**
Some standardization of data and format in process.	**2**
Clinical data is rarely the basis for decisions, and requires accessing paper medical records. Most data is administrative use of encounter data. (N/A for this business process)	**N/A**
Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require.	**2**
Effort to Perform	**2**
Business processes that result in cost management are enhanced.	**2**
Cost Effectiveness	**2**

MITA BCM Qualities & Characteristics	Level
Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	2
Accuracy of Process	**2**
Programs have more consistency with rule creation and application across the Agency.	2
Utility or Value to Stakeholders	**2**
Centralization increases consistency of communications; improves linguistic, cultural, and competency appropriateness; and lowers socio-economic barriers.	2

12.15 Develop and Manage RI Medicaid Performance Measures and Reporting

12.15.1 MITA Business Process

Tier 3: Develop and Manage Performance Measures and Reporting	
Item	**Details**
Description	The Develop and Manage Performance Measures and Reporting process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. This includes the steps involved in defining the criteria by which activities and programs will be measured and developing the reports and other mechanisms that will be used by the Monitor Performance and Business Activity process to track activity and effectiveness at all levels of monitoring. Examples of performance measures and associated reports may be things such as: Goal: *To assure that prompt and accurate payments are made to providers.* Measurement: *Pay or deny 95% of all clean claims within 30 days of receipt.* Mechanism: *Weekly report on claims processing timelines.* Goal: *Accurately and efficiently draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery.* Measurement: *Draw 98% of funds with the minimum time allowed under CMIA.* Mechanism: *Monthly report on funds drawn.* Goal: *Improve healthcare outcomes for Medicaid members.* Measurement: *Reduce emergency room visits by ten percent by assigning a primary care case manager.* Mechanism: *Monthly report comparing emergency room usage by member for the period prior to and after PCCM assignment*.

12.15.2 RI Business Process Overview

The Develop and Manage RI Medicaid Performance Measures and Reporting process is performed by the DHS, Child and Family Services. DHS uses several sources of health outcomes data (public health databases, hospital discharge data, Vital stats etc) for benchmarking and trending over time. Each Managed Care health plan is contractually required to complete three quality improvement projects each year. DHS also does an annual site visit to monitor performance and perform HEDIS, HEDIS "like" and home grown measures as part of the performance goal program.

12.15.3 Business Process Variations

MITA business process definition was not complete within the framework. The version included in assessment report was created for RI based upon standard verbiage.

12.15.4 Systems and Datasets

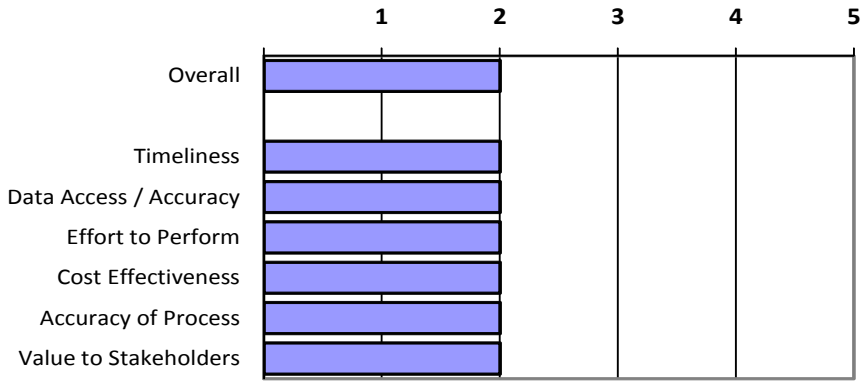
The major systems and datasets that store, transact or exchange data in support of the Develop and Manage RI Medicaid Performance Measures and Reporting process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- SAS – statistical application used for rate determination and data analyses within program management.
- Quality Compass – third party (NCQA) tool used examining quality improvement and benchmarking health plan performance.

12.15.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Develop and Manage RI Medicaid Performance Measures and Reporting process are rated at a Level 2.

Figure 62 Current Maturity Levels by Dimension: Develop and Manage RI Medicaid Performance Measures and Reporting



Examples supporting these Develop and Manage RI Medicaid Performance Measures and Reporting process ratings include the following:

- Industry standard tools are used for benchmarking plan performance
- SAS statistical package is used for analysis of data
- Consistent rules are applied and monitored with annual performance goal program

Table 61 Assessed Maturity Level by MITA Quality: Develop and Manage RI Medicaid Performance Measures and Reporting

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Timeliness exceed legal requirements	**2**
Data Access & Accuracy	**2**
Introduction of automated rules.	**2**
Data is accessed / transferred / received via Web portals, email, dial-up, POS and EDI. Automation increases accuracy of data	**2**
Records are either stored in a single registry (eg, Provider and Member Registry) or federated Registries….	**3**

MITA BCM Qualities & Characteristics	Level
Responses to requests for information are automated (with use of benchmarking tools)	2
Agency business relationships are increasingly hub and spoke vs. point to point with each internal and external party, e.g., the Agency likely has a central point for developing customer communications. These changes improve customers' ability to reliably access the information and services they require	2
Rules/criteria and access points for similar business functions are the same across program areas	2
Effort to Perform	2
Updates are automatically processed (data is automatically updated in MMIS encounter sub-system)	2
Cost Effectiveness	2
Less staff required to perform business process. Automation leads to fewer staff. Responses per day increases.	2
Accuracy of Process	2
More consistency in decision making / rules / validation	2
Utility or Value to Stakeholders	2
Automation and coordination processes enable staff to focus more on member and provider management.	2

12.16 Generate Financial and Program Analysis Report

12.16.1 MITA Business Process

Tier 3: Generate Financial & Program Analysis/Report	
Item	**Details**
Description	It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements. The Generate Financial & Program Analysis/Report process begins with a request for information or a timetable for scheduled correspondence. The process includes: ■ defining the required reports format, content, frequency and media, report's retention, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), ■ retrieving data from multiple sources, e.g., Manage Payment History; Maintain Member Information; Manage Provider Information; and Maintain Benefits/Reference data store; ■ compiling the retrieved data, compiling the data, and ■ formatting into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.

12.16.2 RI Business Process Overview

The Generate Financial and Program Analysis Report process is performed by the DHS, Child and Family Services. This is an ongoing, dynamic process that feeds a monthly financial and program indicators meeting internally. DHS looks across all managed care lines of business including Children with Special Health Care Needs (CSHCN). Expenses are compared to budget fiscal year to date, last fiscal year and projected expenses through the end of the current fiscal year. Cost savings are projected when a new Managed Care model is being proposed but is not looked at prospectively.

12.16.3 Business Process Variations

The Generate Financial and Program Analysis Report business process does not significantly diverge from the MITA business process definition.

12.16.4 Systems and Datasets

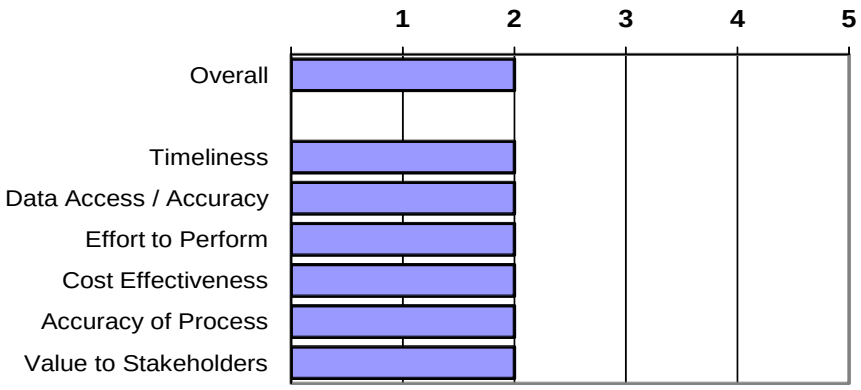
The major systems and datasets that store, transact or exchange data in support of the Generate Financial and Program Analysis Report process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- SAS – statistical application used for rate determination and data analyses within program management.
- Rite Share Access Database – Access database used to analyze cost effectiveness of Rite Share program
- RI-FANS – State's accounting system used for non-MMIS expenditures reporting.

12.16.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Generate Financial and Program Analysis Report process are rated at a Level 2.

Figure 63 Current Maturity Levels by Dimension: Generate Financial and Program Analysis Report



Examples supporting these Generate Financial and Program Analysis Report process ratings include the following:

- Process is "data driven"
- SAS statistical package is used for analysis of data
- Introduction of automation

Table 62 Assessed Maturity Level by MITA Quality: Generate Financial and Program Analysis Report

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**2**
Standardization of data has reduced the time it takes to generate the financial and program analysis report to one month on the average.	**2**
Data Access & Accuracy	**2**
Standardization of the data has synchronized all the data necessary to generate the financial and program analysis report. Data content is validated.	**2**
Standard methodologies have defined the non- centrally located sources for the information needed to generate the financial and program analysis report.	**2**
Effort to Perform	**2**
Efficiency is increased as the process is standardized and the information gathered is more complete and accurate.	**2**

MITA BCM Qualities & Characteristics	Level
Cost Effectiveness	**2**
Standardization reduces the cost to generate the financial and program analysis report and the quality of the process increases.	**2**
Accuracy of Process	**2**
Standardized methodologies and data produce a more accurate and useable financial and program analysis report. Accuracy improves over Level 1.	**2**
Utility or Value to Stakeholders	**2**
Standardization has provided more clear and useful information for stakeholders.	**2**

12.17 Maintain Benefits/Reference Information

12.17.1 MITA Business Process

Tier 3: Maintain Benefits/Reference Information	
Item	**Details**
Description	The Maintain Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter, or Price Claim/Encounter. It can also be triggered by the addition of a new program, or the change to an existing program due to the passage of new State or Federal legislation, or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the receive inbound transaction.

12.17.2 RI Business Process Overview

The Maintain Benefits/Reference Information process is performed by the MMIS Fiscal Agent, HP and overseen by the DHS. The scope of approved services, benefits and reference data included within the Medicaid program are stored within MMIS reference tables and program indicator values. Changes are made at the direction of DHS program or policy staff.

12.17.3 Business Process Variations

The following are the elements in this RI business process that diverge from the MITA definition:

- Request update/change to approved benefits/services within program (This step is not included within the MITA definition but is performed by DHS program or policy staff utilizing the FACN process. HP performs the steps that follow).

12.17.4 Systems and Datasets

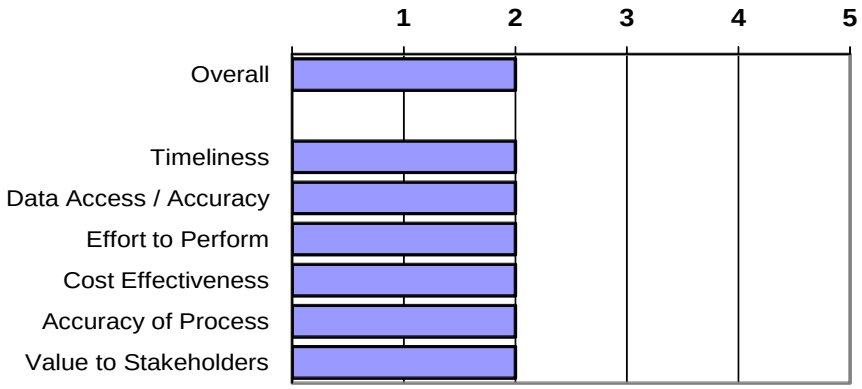
The major systems and datasets that store, transact or exchange data in support of the Maintain Benefits/Reference Information process include:

RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

12.17.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Maintain Benefits/Reference Information process are rated at a Level 2.

Figure 64 Current Maturity Levels by Dimension: Maintain Benefits/Reference Information



Examples supporting these Maintain Benefits/Reference Information process ratings include the following:

- Centralized repository of approved program benefits/reference information
- Consistency in process

- Updates to benefit and reference files must be communicated to the fiscal intermediary via formal written correspondence.

Table 63 Assessed Maturity Level by MITA Quality: Maintain Benefits/Reference Information

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Automation improves timeliness over that at Level 1.	**2**
Data Access & Accuracy	**2**
Use of national data definitions improves accuracy rating over Level 1.	**2**
Due to increased automation, accessibility improves over Level 1.	**2**
Effort to Perform	**2**
Flexibility increases. Use of national data exchange standards (HIPAA) increases efficiency over Level 1.	**2**
Cost Effectiveness	**2**
Standard Development Organizations provide scheduled updates. Staff is involved in adaptations and extensions of the standards provided.	**2**
Accuracy of Process	**2**
Accuracy improves over Level 1 with use of national HIPAA requirements for data.	**2**
Utility or Value to Stakeholders	**2**
Medicaid enterprise begins to identify gaps in levels of satisfaction and stakeholder expectations and priorities.	**2**

12.18 Manage Program Information

12.18.1 MITA Business Process

Tier 3: Manage Program Information	
Item	**Details**
Description	The Manage Program Information business process is responsible for managing all the operational aspects of the Program Information data store, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The Program Information data store receives requests to add, delete, or change data in program records. The data store validates data upload requests, applies instructions, and tracks activity. The Program Information data store provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, through communication vehicles such as batch record transfers, responses to queries, and "publish and subscribe" services.

12.18.2 RI Business Process Overview

The Manage Program Information process is owned by the DHS, Center for Adult Health. The CHOICES Data Warehouse project provides the department with an analytic tool to support financial and utilization analysis. All phases of the CHOICES Data Warehouse project are not complete at the time of the Current View assessment.

12.18.3 Business Process Variations

The Manage Program Information business process does not significantly diverge from the MITA business process definition.

12.18.4 Systems and Datasets

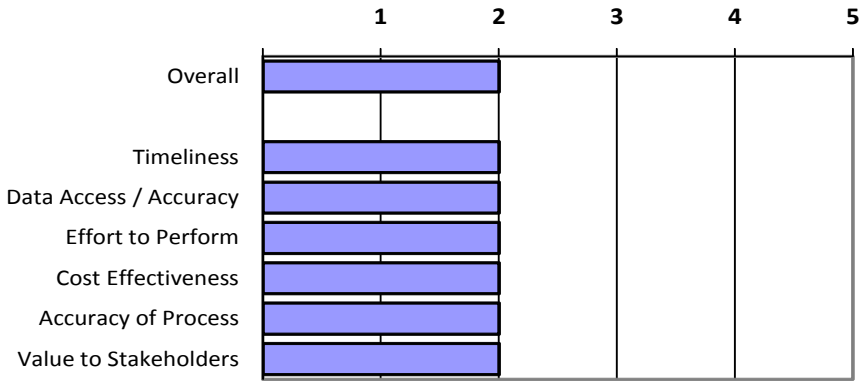
The major systems and datasets that store, transact or exchange data in support of the Manage Program Information process include:

- RI MMIS – RI Medicaid Management Information System used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization
- CHOICES Data Warehouse - Human Services Data Warehouse. Gathers payment, provider, eligibility and case management data from the RI-MMIS, InRhodes, DEA SAMS, Personal Choices, DEA RIPAE, CSM, BHDDH DD, and US Census data into an integrated, knowledge-based system used by staff from DHS and other state organizations.

12.18.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage Program Information process are rated at a Level 2.

Figure 65 Current Maturity Levels by Dimension: Manage Program Information



Examples supporting these Manage Program Information process ratings include the following:

- The update process of bringing data into the CHOICES Data Warehouse is automated

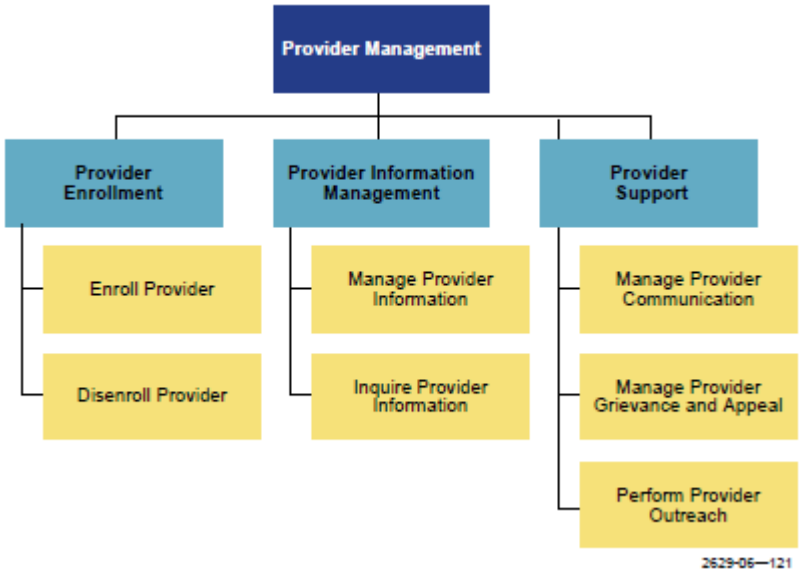
- Data is accessed electronically by multiple users
- Edits are automatically processed at the time data is loaded into the CHOICES Data Warehouse
- Program area staff are able to use the information in the CHOICES Data Warehouse to manage beneficiaries and provider expenditures and utilization

Table 64 Assessed Maturity Level by MITA Quality: Manage Program Information

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Use of Commercial Off The Shelf (COTS) products and tools dramatically improves the turnaround time to produce program information.	**2**
Data Access & Accuracy	**2**
Accuracy and consistency of data used in the process improve over Level 1. Use of COTS packages and HIPAA data standards increases reliability of data.	**2**
The process uses on-line access to data. Use of COTS packages, tools, and HIPAA compliant data improves accessibility.	**2**
Effort to Perform	**2**
Process efficiency greatly improves through automation and HIPAA data standards. In addition, business areas can manage many of their own inquiries.	**2**
Cost Effectiveness	**2**
Cost-effectiveness improves over Level 1 through the use of automation and HIPAA data standards.	**2**
Accuracy of Process	**2**
Additional automation produces more accurate results than at Level 1.	**2**
Utility or Value to Stakeholders	**2**
States begin to identify gaps in levels of satisfaction and stakeholder expectations and priorities.	**2**

13 PROVIDER MANAGEMENT

There are seven business processes defined within the MITA framework for Provider Management.



The RI Medicaid program performs six of the defined business processes:

- Disenroll Provider
- Enroll Provider
- Inquire Provider Information
- Manage Provider Communication
- Manage Provider Grievance and Appeal
- Manage Provider Information

13.1 Enroll RI Medicaid Provider

13.1.1 MITA Business Process

Tier 3: Enroll Provider	
Item	**Details**
Description	The Enroll Provider business process is responsible for managing providers' enrollment in programs, including ■ Receipt of enrollment application data set from the Manage Provider Communication process ■ Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance ■ Validation that the enrollment meets state rules by — Performing primary source verification of verifies provider credentials and sanction status with external entities, including: o Education and training/Board certification o License to practice o DEA/CDS Certificates o Medicare/Medicaid sanctions o Disciplinary/sanctions against licensure o Malpractice claims history o NPDB and HIPDB disciplinary actions/sanctions — Verifying or applying for NPI enumeration with the NPPES — Verifying SSN or EIN and other business information ■ Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill ■ Establish payment rates and funding sources, taking into consideration service area, incentives or discounts ■ Negotiate contracts ■ Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations ■ Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry ■ Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all ■ parties and affiliated business processes, including:

Tier 3: Enroll Provider	
Item	**Details**
	— The Capitation and Premium Payment Area — The Prepare Provider EFT/Check process — The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights ■ Perform scheduled user requested: — Credentialing reverification — Sanction monitoring — Payment rate negotiations — Performance evaluation External contractors such as quality assurance and credentialing verification services may perform some of these steps

13.1.2 RI Business Process Overview

The Enroll RI Medicaid Provider process is overseen by the Department of Human Services (DHS). The MMIS Fiscal Agent, HP, performs the majority of steps identified in the MITA business process for all providers requesting enrollment into the RI Medicaid program; then forwards the application to the DHS for approval. HP completes the enrollement process by adding the provider in the MMIS Provider Subsystem.

The Enroll RI Medicaid Provider process is standard for all Medicaid provider types (e.g., Early Intervention, BHDDH, DCYF, Non-emergency Transport). However some provider types (e.g. Shared Living, PASS, Respite, Personal Assistance and Kids Connect Day Care) require providers to be certified with their program prior to becoming a Medicaid provider.

13.1.3 Business Process Variations

The following are steps in the RI business process that diverge from the MITA business process definition:

- Determine contracting parameters, e.g., … contract terms and maximums, client enrollment levels, panel size, and any contractor specific benefit packages and procedures (provider rates are not determined during the enrollment process.
- Contract license providers are effective on the license date and enrollment expires on the expiration of the license (this step is not defined in the MITA definition but valid for RI).

13.1.4 Systems and Datasets

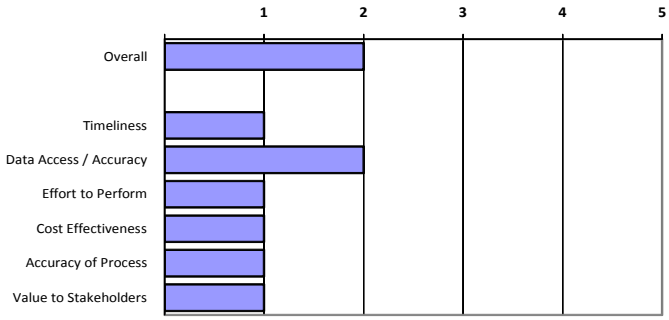
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DOH Online Verification and Complaint Submission Site –used to search for the license of a health professional or register a complaint on a health care professional.

13.1.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Enroll RI Medicaid Provider process are rated at a Level 1 with the exception of Data Access and Accuracy.

Figure 66 Current Maturity Levels by Dimension: Enroll RI Medicaid Provider



Examples supporting these Enroll RI Medicaid Provider process ratings include the following:

- Application data are standardized within the agency
- Applications are paper-based
- Most activities are labor-intensive
- Verification and validation of information is manual
- The NPI is required
- Provider License Number is an identifier of record for paper submission of claims

Table 65 Assessed Maturity Level by MITA Quality: Enroll RI Medicaid Provider

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions on application may take several days but within State regulations.	1
Data Access & Accuracy	**2**
Application data are standardized within the agency.	2
Enrollment records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all participants.	3
The NPI is the identifier of record.	3
Staff perform queries into stored Medicaid provider and claims data to identify providers with specialties and service indicators indicating potential for enrollment as primary care, disease management, and waiver providers.	N/A
Although data comparability is improved, performance data is only periodically measured and requires sampling and statistical calculation.	N/A
Providers, members, and state enrollment staff have secure access to appropriate data on demand. (Level 3 only)	N/A
Access to clinical data improves capability to select providers that meet quality standards. (Level 4 only)	N/A
Effort to Perform	**1**
Verifications are a mix of manual and automated steps.	2
Enrollment processes continue to be handled by siloed programs according to program-specific rules.	2
Providers can submit on paper and electronically via a portal which improves turnaround time. (There is an initiative underway to introduce a Provider Enrollment Web Portal in 2011) (Level 2 only).	N/A
A large staff is required to meet targets for manual enrollment of providers (Relative to RI).	1
Any data exchange partner can send a notification regarding a provider enrolled with the state Medicaid program (Level 4 only).	N/A
External and internal validation sources automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time (Level 4 only).	N/A
Cost Effectiveness	**1**
Requires large numbers of staff (Relative to RI).	1

MITA BCM Qualities & Characteristics	Level
Shared processes and inter-agency collaboration contribute to streamline the process (Level 3 only).	3
Accuracy of Process	**1**
Much of the application information is manually validated.	1
Decisions more consistent than level 1.	2
Due to limited monitoring and re-verification of enrolled providers' status, sanctioned providers may continue to be enrolled.	1
The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.	2
The agency sends verification inquiries to any other agency regarding the status of a provider (Level 3 only).	N/A
The quality of the provider network is improved (Level 3 only).	N/A
Clinical data can be accessed and monitored for measuring performance (Level 4 only).	N/A
Utility or Value to Stakeholders	**1**
In managed care and waiver setting, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population).	2
Staff do not have time to focus on cultural and linguistic compatibility, member satisfaction, or provider performance.	1
Members are assigned to PCPs to coordinate their care.	2
Provider and member satisfaction improves because of speed and accuracy of enrollment process (Level 3 only).	N/A

13.2 Disenroll RI Medicaid Provider

13.2.1 MITA Business Process

Tier 3: Disenroll Provider	
Item	**Details**
Description	The Disenroll Provider business process is responsible for managing providers' enrollment in programs, including: ■ Processing of disenrollment — Requested by the provider — Requested by another Business Area, e.g., the Manage Provider Communication, Monitor — Performance and Business Activities, and Program Integrity Manage Case processes — Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process — Based on failure in the Enroll Provider process, e.g., Provider fails to meet state enrollment requirements ■ Provider fails enumeration or credentialing verification ■ Provider cannot be enumerated through NPPES or state assigned enumerator ■ Lack of applicable rates ■ Inability to negotiate rates or contract ■ Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (e.g., new, resubmission, duplicate) ■ Validation that the disenrollment meets state rules and substantiating basis for disenrollment, e.g., checking death records ■ Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry ■ Prompting the Manage Provider Communication process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including — The Capitation and Premium Payment Area — The Prepare Provider EFT/Check process ■ Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider's patient panel, e.g., PCCM, Lock-in, HCBS and other waiver program, and FFS

Tier 3: Disenroll Provider	
Item	**Details**
	■ Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members

13.2.2 RI Business Process Overview

The Disenroll RI Medicaid Provider process is overseen by the Department of Human Services (DHS). The RI Provider Disenrollment process managed by Provider Management is consistent across all programs.

13.2.3 Business Process Variations

The following are steps in the Disenroll RI Medicaid Provider business process that diverge from the MITA business process definition:

- License Expiration Check if expired, the provider will be disenrolled (HP on behalf of DHS attempt to contact the provider prior to taking action)
- Providers are disenrolled after 18 months of no activity

13.2.4 Systems and Datasets

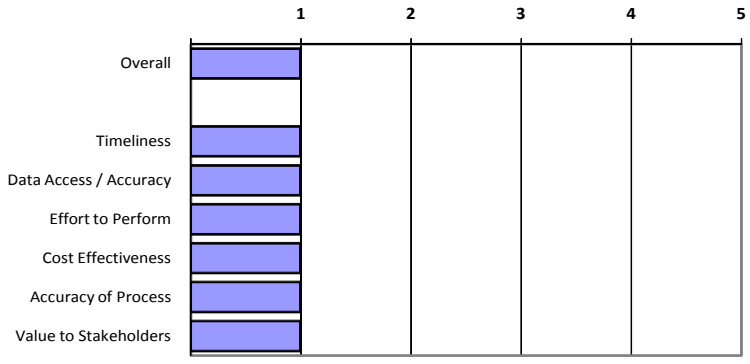
Examples of the major systems that store, transact or exchange data in support of the provider disenrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DOH Online Verification and Complaint Submission Site –used to search for the license of a health professional or register a complaint on a health care professional.

13.2.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Disenroll RI Medicaid Provider process are rated at a Level 1 capability. The process is mostly manual.

Figure 67 Current Maturity Levels by Dimension: Disenroll RI Medicaid Provider



Examples of the qualities and characteristics that support these ratings include the following:

- Requests for disenrollment are not automated
- Local RI staff send paper disenrollment requests to DHS for processing
- Validation of information is manual
- Responses are not immediate

Table 66: Assessed Maturity Level by MITA Quality: Disenroll RI Medicaid Provider

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Most requests to disenroll provider are received and responded to manually via phone, fax, USPS.	1
Responses to requests are immediate. (Level 2 only)	N/A

MITA BCM Qualities & Characteristics	Level
Information can be shared among authorized entities within the state.	N/A
Data Access & Accuracy	**1**
Information is researched manually.	1
Collaborating agencies using the MITA standard interfaces can exchange data on registered providers. (Level 3 only)	N/A
Access is via Web portal and EDI channels. (Level 2 only)	N/A
There may be inconsistencies in responses.	1
Effort to Perform	**1**
Staff research and respond to requests manually.	1
Fewer staff required to support.	2
One stop shop for agencies who share providers. (Level 3)	N/A
Cost Effectiveness	**1**
Requires research staff (due to lack of automation).	1
Number of disenrollment requests per day increases significantly. (Level 2)	N/A
Accuracy of Process	**1**
Responses are manually validated, e.g., via call center audits; stakeholder satisfaction survey.	1
Process complies with agency requirements.	1
Utility or Value to Stakeholders	**1**
Requesters receive the information they need.	1

13.3 Inquire RI Medicaid Provider

13.3.1 MITA Business Process

Tier 3: Inquire Provider Information	
Item	**Details**
Description	The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

13.3.2 RI Business Process Overview

The Inquire RI Medicaid Provider process is overseen by the Department of Human Services (DHS). Authorized staff from BHDDH, DCYF, Early Intervention, Counties, and other state organizations can request provider information through the Provider Search tool available on the RI DHS website. RI DHS Call Center coordinators handles incoming provider inquires. The RI DHS provider inquire process managed by Provider Management is consistent across all programs.

13.3.3 Business Process Variations

The Inquire RI Medicaid Provider business process does not significantly diverge from the MITA business process definition.

13.3.4 Systems and Datasets

The following are examples of the major systems that store, transact or exchange data in support of this process:

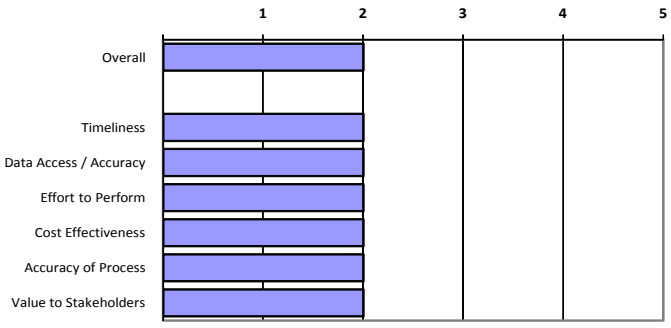
- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.

- DOH Online Verification and Complaint Submission Site –used to search for the license of a health professional or register a complaint on a health care professional.
- Provider Search – an online tool to assist in locating Medical Assistance doctors, specialist, therapist, and other supporting services.

13.3.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Inquire RI Medicaid Provider Information business process are rated at a Level 2 capability.

Figure 68: Current Maturity Levels by Dimension: Inquire RI Medicaid Provider Information



E
xamples of the qualities and characteristics that support these ratings include the following:

- Due to the call center, inquiries regarding provider information can be immediate during normal business hours
- Web-access to provider enrollment information is not available.
- Automation improves access and accuracy. Access is via Provider Search tool on the DHS website.

Table 67: Assessed Maturity Level by MITA Quality: Inquire RI Medicaid Provider Information

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Requests for provider information are automated via AVRS, Web portal, EDI within an agency using agency standards for messages.	2
Responses to routine inquiries are immediate.	2
Information can be shared among authorized entities within the state. (Data sharing is mostly in a electronic format, but lack electronic transfer and requires manual intervention) (Level 3 only)	N/A
Data Access & Accuracy	**2**
Automation improves access and accuracy. Access is via Web portal and EDI channels.	2
Collaborating agencies using the MITA standard interfaces can exchange data on registered providers. One stop shop for agencies who share providers. (Level 3 Only)	N/A
There may be inconsistencies in responses	N/A
Effort to Perform	**2**
Responses to requests to inquire about provider information are automated.	2
Fewer staff required to support.	2
Cost Effectiveness	**2**
Automation leads to fewer staff than Level 1.	2
Number of responses per day increases significantly.	2
Accuracy of Process	**2**
Automation improves accuracy of responses	2
Process complies with agency requirements.	N/A
Utility or Value to Stakeholders	**2**
Requesters receive immediate responses.	2

13.4 Manage RI Medicaid Provider Information

13.4.1 MITA Business Process

Tier 3: Manage Provider Information	
Item	**Details**
Description	The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid. The Provider Registry is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The Provider Registry may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member Registry to add, delete, or change this information in registry records. The Provider Registry validates data upload requests, applies instructions, and tracks activity. The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services. Among the business processes that will interface with the Provider Registry are ■ The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status ■ The Provider Support processes, such as Manage Provider Communication ■ All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check ■ The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information ■ Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information

	■ Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry

13.4.2 RI Business Process Overview

The Manage RI Medicaid Provider Information process is overseen by the Department of Human Services (DHS). The MMIS Fiscal Agent, HP, is responsible for updating the Provider Registry within the MMIS Provider Subsystem. DHS in collaboration with HP performs the steps identified in the MITA business process.

13.4.3 Business Process Variations

The Manage RI Medicaid Provider Information business process does not significantly diverge from the MITA business process definition.

13.4.4 Systems and Datasets

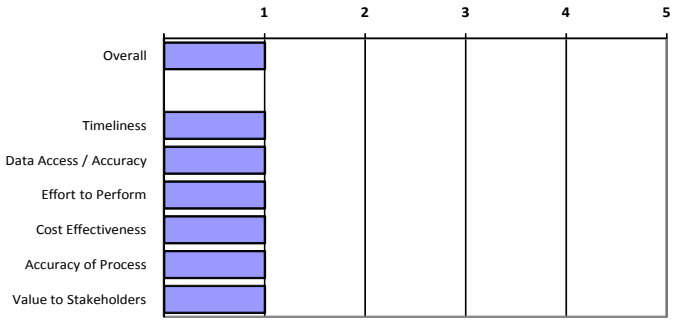
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- Provider Search – an online tool to assist in locating Medical Assistance doctors, specialist, therapist, and other supporting services.

13.4.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Provider Information process are rated at a Level 1 capability.

Figure 69: Current Maturity Levels by Dimension: Manage RI Medicaid Provider Information



Examples of the qualities and characteristics that support these ratings include the following:

- Requests for information updates or requests are paper-based
- Provider Inquires are handled by a provider coordinator
- Most activities are labor-intensive
- Verification and validation of information is manual

Table 68: Assessed Maturity Level by MITA Quality: Manage RI Medicaid Provider Information

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Manual and semi-automated steps require some days to complete update and maintenance process. Changes to provider registry are managed manually.	1
Data exchange partners receive update information instantly. (Level 3 only)	N/A
Data Access & Accuracy	**1**
Provider records are stored in either a single Provider Registry or federated Provider Registries that can be accessed by all users of provider data.	3
Updates are made to data manually.	1

MITA BCM Qualities & Characteristics	Level
Inconsistencies and inaccuracies can go undetected. Duplicate entries may go undetected.	1
Effort to Perform	**1**
Staff perform file updates manually.	1
Nationally interoperable validation sources automatically send notice of change in provider status, eliminating the need to re-verify. (Level 5 only)	N/A
Supports detection of sanctioned providers in real time anywhere in the USA. (Level 5 only)	N/A
Can be expanded to any other country to obtain information on an immigrant or guest provider. . (Level 5 only)	N/A
Cost Effectiveness	**1**
Requires large data entry staff. (Relative to RI)	1
Regional, federated provider registries eliminate redundant overhead. (Level 4 only)	N/A
Accuracy of Process	**1**
Updates are manually validated.	1
NPI is introduced but is translated to local IDs.	2
Process complies with agency requirements.	1
Utility or Value to Stakeholders	**1**
Provider update information is maintained and available to other business processes.	1
Cultural and linguistic matches are made. (Level 2 only)	N/A
Members are assigned to PCPs to coordinate their care.	2
Automated maintenance of provider information ensures that timely, accurate data are available to support member assignment. (Level 2 only)	N/A
Provider and member satisfaction improves because of speed and accuracy of enrollment process. (Level 3 only)	N/A

13.5 Manage RI Medicaid Provider Communication

13.5.1 MITA Business Process

Tier 3: Manage Provider Communication	
Item	**Details**
Description	The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process. Note: Inquires from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, i.e., bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues

13.5.2 RI Business Process Overview

The Manage RI Medicaid Provider Communication process is overseen by the Department of Human Services (DHS). The HP Provider Relations Unit is contractually responsible for handling provider communication functions such as responding to requests for information, maintaining and distributing provider manuals, notifying providers of program and policy changes via bulletins and direct mailers. DHS and HP collectively perform all steps identified in the MITA Manage Provider Communication business process.

13.5.3 Business Process Variations

The Manage RI Medicaid Provider business process does not significantly diverge from the MITA business process definition.

13.5.4 Systems and Datasets

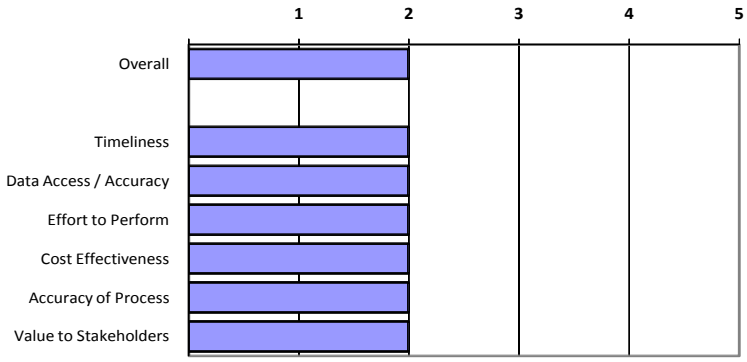
The major systems and datasets that store, transact or exchange data in support of the provider enrollment process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DHS Provider Servcies Website - used by health care providers to obtain Medicaid information including, but not limited to: program updates, newsletters, provider manual, program policy, provider enrollment information, forms and other publication.
- Interactive Web Services - used by health care providers to verify recipient eligibility and benefits; check the status of a submitted claim; check the status of a prior authorization request; pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program; confirm their Medical Assistance payment history for the last 12 months; and view their Remittance Advice (RA) electronically in the paper RA format.
- REVS - telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status.

13.5.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Provider Communication business process are rated at a Level 2 capability.

Figure 70: Current Maturity Levels by Dimension: Manage RI Medicaid Provider Communication



Examples of the qualities and characteristics that support these ratings include the following:

- Providers can request and/or obtain materials in an automated manner including the 1-800 hotline, the Interactive Web Services, REVS, and the internet
- HP Customer Service Helpdesk handles an average of over one hundred thousand calls per year

Table 69: Assessed Maturity Level by MITA Quality: Manage RI Medicaid Provider Communication

MITA BCM Qualities & Characteristics	Level
OVERALL	**2**
Timeliness	**2**
Provider requests and responses are automated via Web, AVRS, EDI with date stamp and audit trail.	2
Interaction between provider clinical data and the agency is automatic. (Level 4 Only)	N/A
Data Access & Accuracy	**2**
Automated responses increase accuracy. Access is via Web portal and EDI channels.	2
Provider information is accessed via either a single Provider Registry or federated provider Registries. Provider information belonging to different entities can be virtually consolidated to form a single view. (Level 3 Only)	N/A

MITA BCM Qualities & Characteristics	Level
The provider clinical record information can trigger messages to and from the provider and the Medicaid agency. For example, if the provider enters information into the clinical record regarding the disease state of the patient, the Medicaid system can send information to the provider re candidacy of the patient for a disease management program. (Level 4 Only)	N/A
Effort to Perform	**2**
Responses to routine provider requests are automated.	2
Collaboration among agencies achieves a one-stop shop for provider inquiries, e.g., mental health provider requests enrollment status from Medicaid, Mental Health Department, MCO. (Level 3 Only)	N/A
Provider registries use standardized contact data, including NPI address standards, to alleviate postal delivery failures. (Level 3 Only)	N/A
Cost Effectiveness	**2**
Automation leads to fewer staff than Level 1. Use of automated tools reduces the number of staff.	2
Number of responses per day increases significantly.	2
Accuracy of Process	**2**
Automation improves accuracy of responses.	2
May encounter obstacles to delivery, e.g., incorrect or lack of contact information. (Level 1 Only - do not encounter obstacle)	N/A
Process complies with agency requirements. This is a level 1 rating only. Process exceeds agency requirements.	N/A
Utility or Value to Stakeholders	**1**
Providers have no delay in obtaining responses.	1

13.6 Manage RI Medicaid Provider Grievance and Appeal

13.6.1 MITA Business Process

Tier 3: Manage Provider Grievance and Appeal	
Item	**Details**
Description	The Manage Provider Grievance and Appeal business process handles provider* appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process. This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. NOTE: States may define “grievance” and “appeal” differently, depending on state laws. *This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.

13.6.2 RI Business Process Overview

The Manage RI Medicaid Provider Grievance and Appeal process is overseen by the Department of Human Services (DHS). DHS has interagency agreements with the Division of Legal Services to handle disputes for RI Medicaid providers. The majority of disputes handled by DHS and Legal are related to cost audit findings, license suspensions and payment withholdings.

13.6.3 Business Process Variations

The Manage RI Medicaid Grievance and Appeal business process does not significantly diverge from the MITA business process definition.

13.6.4 Systems and Datasets

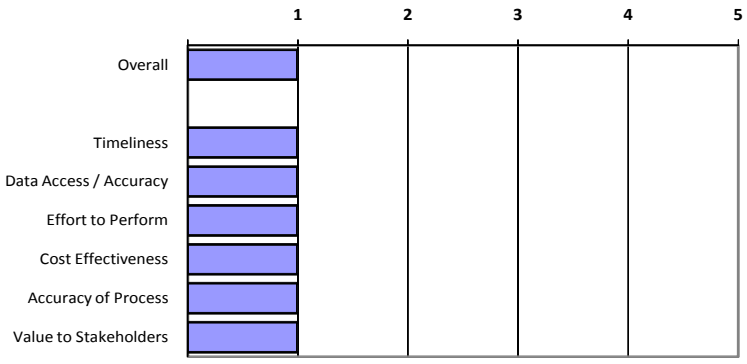
The major systems and datasets that store, transact or exchange data in support of the Manage RI Medicaid Provider Grievance and Appeal process include:

- RI MMIS – used to support Medicaid business functions and maintain information in such areas as provider enrollment; client eligibility, including third party liability; benefit package maintenance; managed care enrollment; claims processing; and prior authorization.
- DOH Online Verification and Complaint Submission Site –used to search for the license of a health professional or register a complaint on a health care professional.

13.6.5 Maturity Characteristics

As shown in the graphic and table that follows, all aspects of the Manage RI Medicaid Provider Grievance and Appeal Business Process are rated at a Level 1 capability.

Figure 71: Current Maturity Levels by Dimension: Manage RI Medicaid Provider Grievance and Appeal



Examples of the qualities and characteristics that support the lower level ratings include the following:

- Provider grievances and appeals must be submitted to DHS in a formal letter.
- The process is all manual including correspondence generation, research and analysis and scheduling.
- Case information maintained in case folder is only available to DHS staff, is not Web enabled and does not interface with other systems.
- The process is labor-intensive which results in some scheduling back logs.

Table 70: Assessed Maturity Level by MITA Quality: Manage RI Medicaid Provider Grievance and Appeal

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
This is an all-manual process.	1
Confidential documents are transferred by certified mail.	1
Responses to research questions within the agency are immediate. (Level 2 only)	N/A
Cases typically require months to complete.	1
Data Access & Accuracy	**1**
Information is researched manually.	1
Access is via Web portal and EDI channels. (Level 2 only)	N/A
Effort to Perform	**1**
There may be inconsistencies in responses.	1
MITA standard interfaces are also used for inquiry and response for acquisition of information needed to build the case. (Level 3 only)	N/A
The original case against a provider may be triggered directly from the clinical record. This is a paradigm shift that introduces a new business process. (Level 4 only)	N/A

MITA BCM Qualities & Characteristics	Level
Medicaid collaborates with other health and human services agencies that manage appeals to create a one-stop shop model for both provider and customer appeals. (Level 3 only)	N/A
Cost Effectiveness	**1**
Process is labor intensive. Results take several months.	1
Standardization of input and case results allows staff to focus on analytical activities. (Level 3 only)	N/A
Regional, federated provider registries eliminate redundant overhead. (Level 4 only.)	N/A
Accuracy of Process	**1**
Terms of the settlement or results of the hearing are manually documented according to the administrative rules of the state.	1
There may be inconsistencies between similar cases. Process complies with agency requirements.	1
Utility or Value to Stakeholders	**1**
Business process complies with agency and state requirements for a fair hearing and disposition.	1

13.7 Perform Provider Enrollment Certification

13.7.1 MITA Business Process

Tier3: Provider Enrollment Certification	
Item	**Details**
Description	The Provider Enrollment Certification business process is responsible for certifying Medicaid providers in the following programs prior to applying to become a Medicaid provider. ■ Shared Living ■ Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation (CEDARR) Family Centers ■ Respite ■ Personal Assistance Services and Support (PASS) ■ Home Based Therapeutic Services (HBTS) ■ Kid Connect Day Care ■ Lead Center ■ Fiscal Agents for LTC case management ■ Local Education Agencies (school departments must sign an Interagency Agreement with the DHS prior to applying to become a Medical Assistance Provider) Providers for each program must meet program specific certification criteria before certification is granted. Once deemed "certified", the provider must apply to become a Medicaid provider following the Enroll RI Medicaid Provider business process.

13.7.2 RI Business Process Overview

The Perform Provider Enrollment Certification business process is overseen by the DHS and performed for various provider types within the RI Medicaid program. Each provider type has a defined set of required standards which are in compliance with federal and state regulations.

The Perform Provider Enrollment Certification process is applicable to various programs within the Medicaid program:

- Shared Living

- Comprehensive Evaluation Diagnosis Assessment Referral and Reevaluation (CEDARR) Family Centers
- Respite
- Personal Assistance Services and Support (PASS)
- Home Based Therapeutic Services (HBTS)
- Kid Connect Day Care
- Lead Center
- Fiscal Agents for LTC case management
- Local Education Agencies (school departments must sign an Interagency Agreement with the DHS prior to applying to become a Medical Assistance Provider)

Once the provider becomes certified, they must follow the Enroll RI Medicaid Provider business process to become a Medicaid provider.

13.7.3 Business Process Variations

This business process is not found in the MITA Framework 2.0 and has been created to address a RI specific business process.

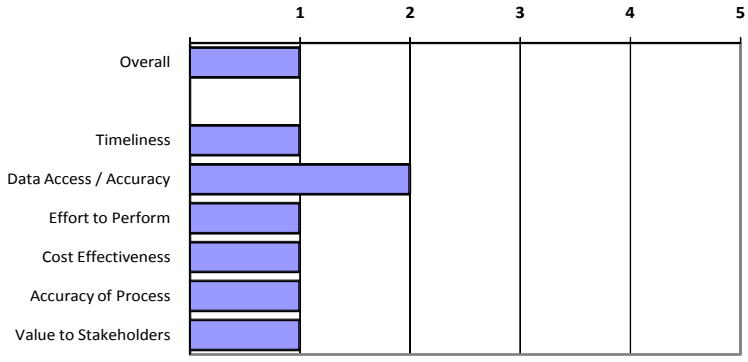
13.7.4 Systems and Datasets

The Perform Provider Enrollment Pre-Certification process is a manual process not supported by any of the major RI systems.

13.7.5 Maturity Characteristics

As shown in the graphic and table that follows, most aspects of the Perform Provider Enrollment Certification process are rated at a Level 1 with the exception of Data Access and Accuracy.

Figure 72 Current Maturity Levels by Dimension: Perform Provider Enrollment Certification



Examples supporting these Perform Provider Enrollment Certification process ratings include the following:

- Applications are paper-based
- Most activities are labor-intensive
- Verification and validation of information is manual
- The NPI is not required for Certification

Table 71 Assessed Maturity Level by MITA Quality: Perform Provider Enrollment Certification

MITA BCM Qualities & Characteristics	Level
OVERALL	**1**
Timeliness	**1**
Decisions on application may take several days but within State regulations.	1
Data Access & Accuracy	**2**
Application data are standardized within the agency.	2
Enrollment records for different programs are stored separately.(Applicable for the pre-certification applications)	2
The NPI is the identifier of record.	N/A

MITA BCM Qualities & Characteristics	Level
Staff perform queries into stored Medicaid provider and claims data to identify providers with specialties and service indicators indicating potential for enrollment as primary care, disease management, and waiver providers.	N/A
Although data comparability is improved, performance data is only periodically measured and requires sampling and statistical calculation.	N/A
Providers, members, and state certification staff have secure access to appropriate data on demand. (Level 3 only)	N/A
Access to clinical data improves capability to select providers that meet quality standards. (Level 4 only)	N/A
Effort to Perform	**1**
Staff contact external and internal credentialing and verification sources via phone, fax.	1
Enrollment processes continue to be handled by siloed programs according to program-specific rules.	2
Providers can submit on paper and electronically via a portal which improves turnaround time.(Level 2 only. Certification applications are all on paper).	N/A
A large staff is required to meet targets for manual certification of providers (Relative to RI).	1
Any data exchange partner can send a notification regarding a provider certification with the state Medicaid program (Level 4 only).	N/A
External and internal validation sources automatically send notice of change in provider status, eliminating the need to re-verify; supports detection of sanctioned providers in real time (Level 4 only).	N/A
Cost Effectiveness	**1**
Requires large numbers of staff (Relative to RI).	1
Shared processes and inter-agency collaboration contribute to streamline the process .	3
Accuracy of Process	**1**
Much of the application information is manually validated.	1
Decisions more consistent than level 1.	2
Due to limited monitoring and re-verification of enrolled providers' status, sanctioned providers may continue to be enrolled	1
The emphasis on managed care and waiver programs encourages more scrutiny of and reporting to national databases.	2
The agency sends verification inquiries to any other agency regarding the status of a provider (Level 3 only).	N/A
The quality of the provider network is improved (Level 3 only).	N/A

MITA BCM Qualities & Characteristics	Level
Clinical data can be accessed and monitored for measuring performance. (Level 4 only).	N/A
Utility or Value to Stakeholders	**1**
In managed care and waiver settings, guidelines ensure adequacy of network (i.e., ratio of number, type, and location of provider to size and demographics of member population).	2
Staff do not have time to focus on cultural and linguistic compatibility, member satisfaction, or provider performance.	1
Members are assigned to PCPs to coordinate their care.	N/A
Provider and member satisfaction improves because of speed and accuracy of enrollment process (Level 3 only).	N/A